RHODE ISLAND

MARCH, 1961

Medical Journal

Volume XLIV, No. 3

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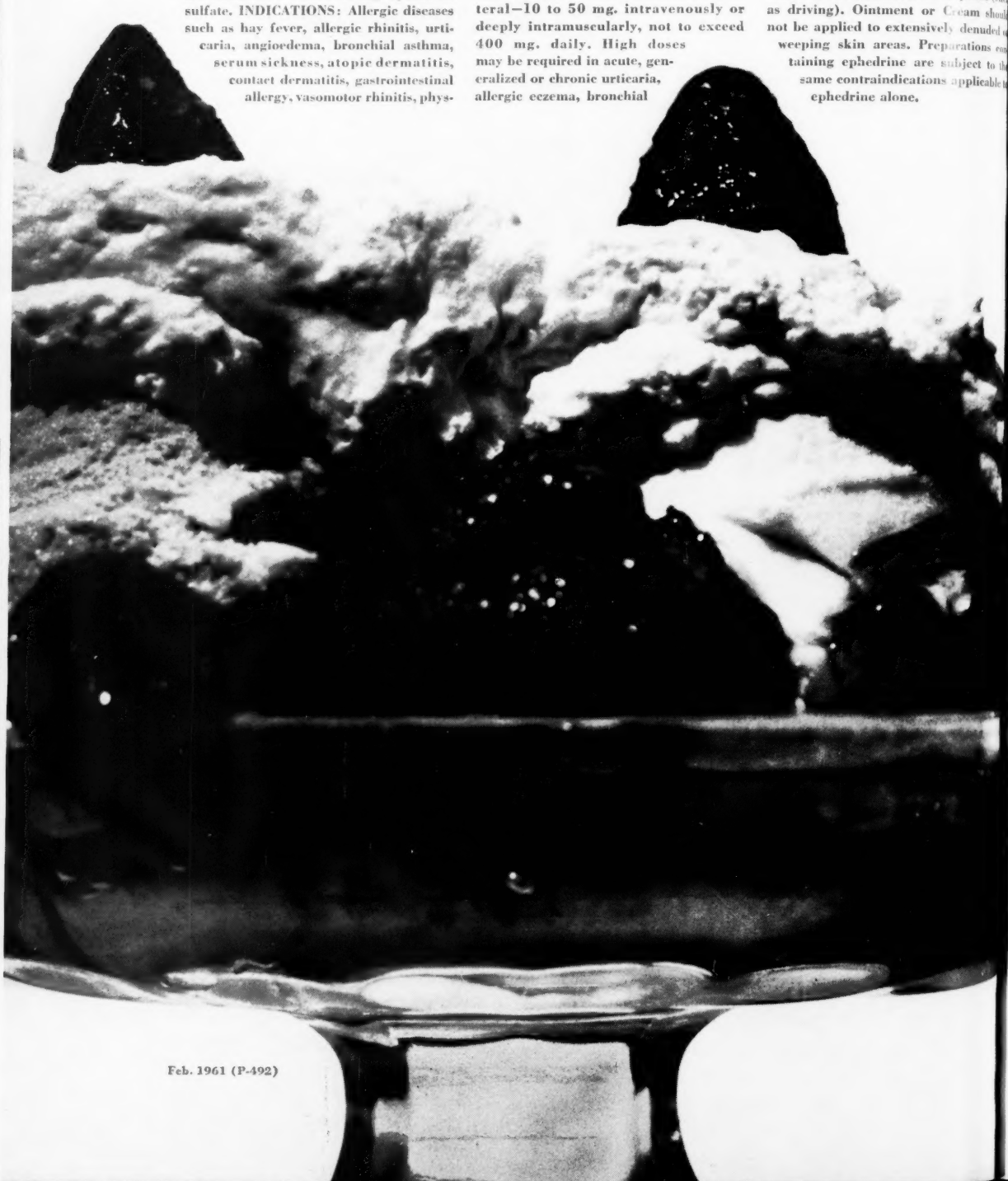
BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis). Kapseals® of 50 mg.; Capsules of 25 mg.; Emplets® (enteric-coated tablets) of 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg. per cc. with 1:10,000 benzethonium chloride as a germicidal agent; Elixir, 10 mg. per 4 cc.; 2% Ointment (water-miscible base); Kapseals of 50 mg. BENADRYL HCl with 25 mg. ephedrine sulfate. INDICATIONS: Allergic diseases such as hay fever, allergic rhinitis, urticaria, angioedema, bronchial asthma, serum sickness, atopic dermatitis, contact dermatitis, gastrointestinal allergy, vasomotor rhinitis, physical allergies, and allergic transfusion reactions, also postoperative nausea and vomiting, motion sickness, parkinsonism, and quieting emotionally disturbed children. Parenteral administration is indicated where, in the judgment of the physician, prompt action is necessary and oral therapy would be inadequate. DOSAGE: Oral—adults, 25 to 50 mg. three or four times daily. Children, 1 or 2 teaspoonfuls of Elixir three or four times daily. Parenteral—10 to 50 mg. intravenously or deeply intramuscularly, not to exceed 400 mg. daily. High doses may be required in acute, generalized or chronic urticaria, allergic eczema, bronchial asthma, and status a[illegible]matic[illegible] PRECAUTION: Avoid sub[illegible]taneous [illegible] perivascular injection. Sing[illegible] parenter[illegible] dosage greater than 100 m[illegible] should b[illegible] avoided, particularly in hyp[illegible]tension an[illegible] cardiac disease. Products [illegible]ontainin[illegible] BENADRYL should be use[illegible] cautiousl[illegible] with hypnotics or other sedat[illegible]ves; if atro[illegible] pine-like effects are undesira[illegible]le; or if th[illegible] patient engages in activities requirin[illegible] alertness or rapid, accurate re[illegible]ponse (suc[illegible] as driving). Ointment or Cream should[illegible] not be applied to extensively denuded o[illegible] weeping skin areas. Preparations co[illegible] taining ephedrine are subject to th[illegible] same contraindications applicable t[illegible] ephedrine alone.



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The RHODE ISLAND MEDICAL JOURNAL

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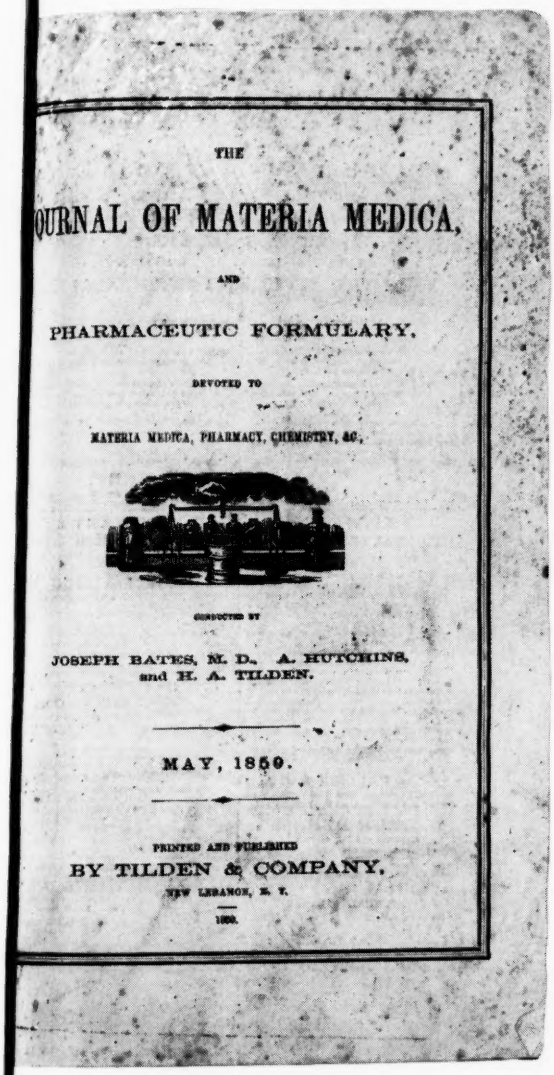
A 137 year old tradition with Tilden...



THE

JOURNAL OF MATERIA MEDICA,

AND

PHARMACEUTIC FORMULARY,

DEVOTED TO

MATERIA MEDICA, PHARMACY, CHEMISTRY, &c.,

CONDUCTED BY

JOSEPH BATES, M. D., A. HUTCHINS,
and H. A. TILDEN.

MAY, 1850.

PRINTED AND PUBLISHED
BY TILDEN & COMPANY,
NEW LEBANON, N. Y.

1850.

FRONTISPIECE OF THE FIRST MATERIA MEDICA.
Printed in the U.S.A. by the Tilden Company the oldest pharmaceutical manufacturing house in America, founded in 1824. (A reproduction of this antiquity for your personal library is available on request.)

To provide the reliable pharmaceuticals most useful in your practice of medicine today

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A triple sulfa formula with antihistamines, bronchodilator and expectorant for the patient's total management.
Usage: alone, as adjunctive therapy following a course of antibiotics, or to prevent secondary bacterial invasion in virus infections.

FORMULA	ADVANTAGE
Sulfadiazine Sulfamerazine Sulfamethazine	No serious renal complications-infrequent crystalluria. Safer, therapeutic blood levels achieved and maintained. Fewer sulfonamide hypersensitivity reactions.
Pyrilamine Maleate Phenyltoloxamine Dihydrogen Citrate	These proven antihistamines provide relief of allergic manifestations, thus minimizing the risk of side effects encountered with single preparations of comparable potency.
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Ephedrine Sulfate	This bronchodilator potentiated by the antihistamines provides the much needed symptomatic relief of bronchial spasm, congestion, dyspnea, and wheezing.

DOSAGE: Children—1 teaspoonful or 2 tablets every 4 hours, or in accordance with body weight.
Adults—2 teaspoonfuls or 4 tablets every 4 hours, or as determined by the physician.

FORMULA:

Sultussin Liquid
Each teaspoonful (5 cc.) provides:

Sulfadiazine	0.166 Gm.
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Sulfamethazine	0.166 Gm.
Pyrilamine Maleate	6.25 mg.
Phenyltoloxamine Dihydrogen Citrate	6.25 mg.
Glyceryl Guaiacolate	50.0 mg.
Ephedrine Sulfate	5.0 mg.

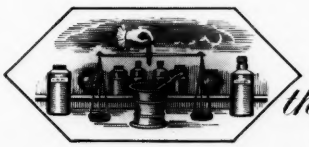
Sultussin Tablets
Each tablet provides:

Sulfadiazine	0.083 Gm.
Sulfamerazine	0.083 Gm.
Sulfamethazine	0.083 Gm.
Pyrilamine Maleate	3.125 mg.
Phenyltoloxamine Dihydrogen Citrate	3.125 mg.
Glyceryl Guaiacolate	25.0 mg.
Ephedrine Sulfate	2.5 mg.

WARNING: Constantly supervise patient, as with all sulfonamides, and prescribe high fluid intake. Antihistamines may cause drowsiness or other side effects in susceptible individuals. Patients should not drive a car or operate dangerous machinery while taking this preparation. Ephedrine sulfate should be used with caution in the presence of cardiac disease, hypertension or hyperthyroidism.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Liquid in 4 oz. and pint bottles. Tablets, bottles of 50 and 100. Available at all pharmacies.



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THE MAIL BOX

February 3, 1961

Editor,
Rhode Island Medical Journal
Providence, R. I.

Dear Editor:

Apropos to your article on generic *vs.* trade names of drugs, shortly after the LIFE magazine article on this subject last year I made a very limited survey of the situation as it affected my patients' pocketbooks.

For a considerable time I have routinely prescribed "Serpasil" when I felt reserpine was the drug of choice for a particular patient. After the article appeared I used the generic name only for thirty consecutive prescriptions, and followed up with each patient regarding the cost. In every case the patient was charged the usual price for "Serpasil." In twenty-seven instances the drug dispensed by the pharmacist appeared to be "Serpasil" when compared to a known tablet. Thus, in three cases the pharmacist appears to have dispensed another brand, presumably lower in cost but the charge to the patient was unchanged.

I talked with two of the pharmacists who had dispensed "Serpasil" and was informed by both that when they had a choice they routinely dispensed the higher grade product for the better protection of my patient and me, assuring me that when my prescriptions were filled in their stores my patients would receive only the finest products.

If this pattern indicates the result of universal prescribing by generic name I see no saving to my patients and I do not feel my use of a trade name will place the blame for high prescription costs on me.

I know there is much more to this problem and no conclusive facts are established here.

Sincerely yours,
A. LLOYD LAGERQUIST, M.D.

Dear Doctor Goldowsky:

The editorial, *Chemical and Generic vs. Trade Names,* in the January 1961 issue of the RHODE ISLAND MEDICAL JOURNAL has come to our attention and has been circulated among our staff. Likewise, we have added this title to a current and continuing bibliography of articles about the pharmaceutical industry that have appeared in the medical press.

We are appreciative of your interest in publishing this timely editorial for the many readers of the RHODE ISLAND MEDICAL JOURNAL.

Sincerely,
ROBERT J. BENFORD, M.D.
Director of Medical Relations
Pharmaceutical Manufacturers Association

I say this with all the sincerity of which I am capable: If we undetermine our fundamental principles, and impair our fiscal solvency in the next 25 to 30 years as we have in the past quarter of a century, I cannot believe our democracy will survive.

Individual liberties and rights are among the fundamental principles which have made our country, in a brief span of time, the greatest democracy in all the world. These principles must be protected and preserved. There are serious indications that we need to be reminded of this.

Our strength is being sapped by the paternalism of Federal bureaucracy grown too big, usurpation of power by the Supreme Court grown too mighty, and force of labor leaders grown too arrogant. These are undermining our system, changing our attitudes, and hobbling our will for freedom.

... U. S. Senator Harry F. Byrd, as reported in *Spotlight,* issued by the Committee for Constitutional Government.

Many groups have considered over the years the need for training additional physicians and dentists in Connecticut. Now that they have reached general agreement on the question, I shall include in my proposed budget funds for a definitive study of the advisable location, operation and financing of a medical-dental school as an adjunct of the University of Connecticut.

... GOV. JOHN DEMPSEY, in his message to the Connecticut General Assembly, January 24, 1961.

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J. Merrill Gibson, M.D.
(ex officio)

BOOK REVIEWS

EPIDEMIC by Frank G. Slaughter. Doubleday & Company, Inc., Garden City, N. Y., 1961. $3.95

This fast-moving tale of 1965 sets itself romping from one end of Manhattan to the other. Mr. Slaughter bases the book's action on the incredible entry of the black plague into a modern metropolis. Sickness and death spread quickly from person to person, block to block; panic eats into the heart of the city. This killer is soon joined by an equally dangerous companion, Communist sabotage.

Human character is shown in all its facets as people react to this challenge. Drastic measures are taken to curb the spread of the disease, and some interesting sleuthing is carried on in seeking the identity of the subversive master mind.

A surprising climax marks the end of this absorbing fictional narrative.

I am sure that many a physician would enjoy entering into the vivid and often startling world which Frank Slaughter has created in this, his latest novel.

NANCY KNOWLTON HEINKEL

A SYSTEM OF MEDICAL HYPNOSIS by Ainslie Meares. W. B. Saunders Co., Phil., 1960. $10.00

A person in writing a book such as this reveals much of himself. Doctor Meares' reputation in Australia as a very sincere, reputable person, a good hypnotist, clear writer and good lecturer shines through his book. He has written in clear detail with patience and sincerity. He defines as he goes. The outline of the book is simple though the table of contents looks complicated.

Doctor Meares gives the history of the use of hypnosis. He feels that, with the acceptance, development, and insights of psychoanalysis, hypnosis can now be used more healthily. He admits not being able to account for the phenomenon of the hypnotic state. He tells ways of inducing it and his own methods of choice. He discusses how to use it, when to use it and when not to, what to expect of it, and what not to expect. Doctor Meares has achieved his goal of presenting "medical hypnosis as I practice it." He defines medical hypnosis as "a system of treatment in which various practices are linked each to each by their clear relation to underlying psychodynamic theory." All hypnosis involves the client's reaction to suggestion. Doctor Meares contrasts this with psychotherapy which he specifies as "insight therapy."

Much of what he says and repeatedly emphasizes has to do with "rapport" and the doctor-patient relationship and the relief of anxiety. This material would be useful and helpful to any physician in his practice. Doctor Meares also stresses the physician's need to know and understand himself and his own motivations as the other part of the intimate patient-physician partnership. This may relieve the physician of his own anxieties and leave him freer to use his discriminating ability more objectively and perhaps with more sensitivity. There is an interesting section on the effect on the therapist himself of the practice of hypnosis. This section might also be insight-provoking to any physician practicing in any area of medicine.

The book will be disappointing to those who look to hypnosis as a one-shot short-cut to helping people. It illustrates that there are no short-cuts in interpersonal relationships, that there is no magic in helping people, and that all treatment has realistic limitations.

Doctor Meares believes in the use of passive (rather than aggressive) induction of hypnotic states because today's patients are more sophisticated and more authority-resistant and because there is less chance of the therapist's losing face if, as often happens, he doesn't accomplish what he started out to achieve. The author grades hypnotic states from simple relaxation to deep hypnosis. He grades the use from simple relaxation to hypnoanalysis with abreaction. He feels hypnosis could be useful in pre- and post-operative states but not as an anesthetic. "The way in which it is at present being used in this area suggests hysteroid motivation on the part of the practitioners." Doctor Meares believes that hypnosis, as any medical treatment, is useful when used with discrimination by properly trained and experienced, ethical physicians.

JOSEPH M. ZUCKER, M.D.

FROM STERILITY TO FERTILITY. A Guide to the Causes and Cure of Childlessness by Elliot E. Philipp. Philosophical Library, Inc., N. Y., 1957. $4.75

This book, by a practicing obstetrician and gynecologist from England, is designed to provide information for childless couples.

It is well written, contains helpful diagrams and would be valuable as supplementary reading for patients undergoing investigation of their infertility.

SUMNER RAPHAEL, M.D.

IL METICCIATO DI GUERRA E ALTRI CASI (War mulattoes and other cases) by L. Gedda, A. Serio and A. Mercuri. Foreword by R. Ruggles Gates, pp. 398, Edizioni Istituto Mendel, Roma, 1960. Lire 10.000

The eminent geneticist Gedda and his collaborators studied a series of forty-four war mulattoes (hybrids), from eight to twelve years of age, thirty-four boys and twelve girls, thirty-five offspring of mating between Negro men and white women, six offspring of a mixed group (Polynesian-Italian, American Indian-Italian) during the last war in Italy.

The study consists in measurements, colors of skin, color and type of hair, shape of nose, lips, X rays of bones, encephalograms, basal metabolism, hematograms, inheritance patterns, rate of growth, and psychometric tests.

Mulattoes are subgrouped as follows: border mulattoes, slave mulattoes, colonial mulattoes, war mulattoes, and melting pot mulattoes (this last subgroup due to the modern way of international connections).

The cases are described in detail. The printing and the illustrations in black and white and color are excellent. The colors of the skin are indicated according to the R. Ruggles Gates chromatic scale.

F. RONCHESE, M.D.

OFFICE DIAGNOSIS by Paul Williamson, M.D. W. B. Saunders Co., Phil., 1960. $12.50

This book is a unique approach to the art of office practice. As such, it contains valuable attitudes, insights and factual material. It is well, however, that the author disclaims universal appeal, since practice is so completely an individual operation, for the work has decided limitations.

In 460 pages, the common, basic data relating to diagnosis of all the systems and most specialties is, of necessity, covered superficially. As the work of a single individual, the text is uneven in quality when compared with a carefully edited compendium by authoritative specialists.

OFFICE DIAGNOSIS will best serve new practitioners whose house officerships have been straight services. If these young scientists can be helped to develop the art of relating to their patients affirmatively, can accept working hypotheses as the expedient bases for management, and can be resigned to the fact that first impressions and final diagnosis may differ, the work will have served its purpose.

It is to be hoped that future editions will omit qualifying adjectives in the consultation sections, such as, "If your patient's condition becomes worse . . . consult a *competent* surgeon." Otherwise, the colloquial style does not detract.

EDMOND B. SINCLAIR, M.D.

SYNOPSIS OF GYNECOLOGY by Robert J. Crossen, Daniel W. Beacham & Woodard D. Beacham. 5th ed. The C. V. Mosby Co., St. L., 1959. $6.50

This is an excellent handbook, aimed primarily at medical students, but equally well suited for use by house officers and physicians who wish a brief, concise, and up-to-date review of gynecology. Admittedly it cannot offer detailed coverage of any subject, but does well within its limitations. It is easy to read on several accounts: the organization is good; extraneous details are lacking; and the authors' wide clinical experience and clarity of thought in presenting same are apparent on nearly every page. Two new chapters have been added on endometriosis and the complications of pregnancy, twelve chapters have been completely rewritten, and the remainder have been revised and updated, according to the authors' statement. The chapter on history taking and gynecologic examination in particular impressed me with its thoroughness.

PAUL A. BLACKMORE, M.D.

COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT. Edited by Curtis P. Artz, M.D. & James D. Hardy, M.D. W. B. Saunders Co., Phil., 1960. $23.00

This imposing volume of 1,075 pages contains the contributions of seventy-one authors in the form of monographs arranged as fifty-seven chapters, covering first, complications of a nonspecific nature, and toward the end of the book, complications of specific therapeutic procedures. The authors selected are for the most part recognized authorities in their fields, and the material presented is complete. In perusing this volume, one is struck with the inclusion of many sections which would be found in any general textbook of surgery, to the point where the reviewer wonders whether surgery itself is the study and avoidance of complications. For example, the first chapter, titled *Infections in Surgery*, might easily be the lead chapter in any surgical text. The ensuing five chapters are likewise on general subjects and Chapter Six is a good review of normal and abnormal clotting mechanisms. Postoperative pulmonary complications are covered in Chapter Nine, and as might be expected there are frequent overlapping references to the same subject later in the book. The chapters on

continued on next page

Cardiac Arrest, Complications of Anesthesia, Complications of Gastro-intestinal Intubation, and *Complications of Common Fractures* are excellent and very well worth reading. Chapter Twenty-two on the prevention of the spread of cancer is excellent but again might have an equal place in a general textbook of surgery.

It might be noted that, despite the completeness of the volume, the reviewer was unable to find any reference under *Gastric Resection* to the use of a decompressing catheter in an uncertain duodenal stump, although drainage of the area is mentioned.

The format, index, and illustrations of the book are excellent, and many useful references are provided at the end of each chapter.

Although each chapter taken individually makes worthwhile reading, the general impression created by the multiple author technique, which is currently popular, is that of a repetitious and somewhat disjointed collection of monographs. The book should make a good reference volume for the resident or occasional surgeon to whom specific information, easily located, must be readily available. The experienced surgeon, whose practical experience is based on sound general principles, may find in it some new technical suggestions. The impression still remains with this reviewer that complications can be adequately covered in a good general surgical text.

JOHN D. PITTS, M.D.

THE PATHOLOGY OF CEREBRAL PALSY
by Abraham Towbin, M.D. Charles C Thomas, Springfield, Ill., 1960. $8.00

THE PATHOLOGY OF CEREBRAL PALSY is a well-written and well-illustrated monograph about a subject which has climbed into the limelight during the past fifteen years. The author summarizes well current etiological concepts of cerebral palsy, and describes in detail the principal pathological conditions known to be associated with the clinical syndrome, Cerebral Palsy. These conditions are: (1) systemic disorders producing brain lesions, (2) local intracranial pathogenetic processes; and (3) developmental defects of the brain; hereditary or induced.

In the first category, systemic disorders, anoxia neonatorum prematurity, erythroblastosis fetalis, and sepsis neonatorum are major offenders. Anoxia can produce a variety of morphological cerebral changes such as parenchymal necrosis, lobar sclerosis, cystic lesions, and status marmoratus. Prematurity is usually associated with hemorrhage and necrosis and erythroblastosis fetalis with kernicterus.

In the second category, mechanical injuries produce hemorrhage, contusion, and laceration of the brain and its membranes. Circulatory disorders (thrombosis and embolism) produce hemorrhage

and ischemia, while hydrocephaly causes damage to the motor cortex due to compression and thinning of the walls.

The third category, developmental defects, produces arrest of growth and aberrant differentiation of cerebral tissue.

This book will be of interest to pathologists, obstetricians, pediatricians, neurologists, and neurosurgeons, and also to others who are interested in "Cause and Effect" in a group of children with heterogeneous clinical signs and symptoms. It emphasizes the poor relationship between clinical symptomatology and pathological findings. It is recommended for its clear writing and conciseness of approach.

ERIC DENHOFF, M.D.

REP. FOGARTY ON HEALTH PERSONNEL SHORTAGES

(Reprinted from the CONGRESSIONAL RECORD, January 25, 1961)

On several occasions I have called the attention of the House to the rapidly growing shortage of physicians, dentists, and other health workers in the United States. The shortage stems largely from three developments in American life — the rapid population growth, with the greatest increase in the younger and older age groups which require most medical service; from increased demands for medical service; and from the expansions in medical research which require more physicians.

In my discussions of the dimensions of the problem, I have urged the House to move swiftly in two specific directions — first, *to provide Federal financial assistance in the expansion of existing professional schools* and *to aid in the construction of the needed new schools,* and, second, *to provide medical and dental scholarships.*

Today I will add a third part to the program for increasing the supply of physicians and other health personnel in order to protect the maintenance of our present health standards and to safeguard our investment in medical research and medical care facilities.

The bill I am introducing would make possible Federal grants to *augment basic operating incomes of our schools of medicine and dentistry. . . .*

The legislation I am proposing . . . calls for action on the part of the Congress to assist schools of medicine — including osteopathy — and schools of dentistry in meeting their operating costs up to but not exceeding 50 per cent. As I stated earlier, these funds would supplement and could not be used to replace funds currently being used.

Specifically, this legislation would provide for annual block grants to each school for a period of 10 years, plus an additional amount based on the number of students enrolled. Eligibility for this Federal assistance would be confined to public and nonprofit institutions within the United States and exempt from Federal income tax. . . .

150th Annual Meeting

May 2 and 3, 1961

RESEARCH DAY PROGRAM

Saturday, April 15, 1961, 9:00 A.M. – 12:00 NOON

George Building Auditorium, R. I. Hospital

Renal Hypothermia
JOHN B. LAWLOR, M.D., Director
Artificial Kidney Laboratory
SHU H. YOON, M.D., Assistant Resident
ERNEST K. LANDSTEINER, M.D., Chief
Department of Urology

A Study of Possible Immune Mechanisms in a Patient with Adrenal Cortical Insufficiency
RICHARD K. MEAD, M.D., Resident

Chromosome Counting: Preliminary Studies
MISS BARBARA BARKER, M.S., Research Associate
PATRICIA FARNES, M.D., Resident
HERBERT FANGER, M.D., Director
Department of Pathology

Augmentation of Cardiovascular Function by Veno-arterial Perfusion
WALTER E. FARIN, M.D., Fellow in Cardiology

Combined Actinomycin-Alkylating Therapy in Treatment of Advanced Cancer — Preliminary Observations
LOUIS A. LEONE, M.D., Director in Cancer Research

The Distribution of Atherosclerotic Plaques Among Cerebral Arteries
ARTHUR K. PARPART, JR., M.D., Junior Resident

LECTURE

Clinical Use of Glycerolized Frozen Blood
HUGH M. PYLE, M.D., Boston, Mass.

EXHIBITS

1. *Intramuscular Decadron* (Dexamethasone) *for Treatment of Acute Laryngotracheobronchitis*
GEORGE K. BOYD, M.D., Senior Resident

2. *Pulse Duplicator for the Study of Postmortem Cardiac Valve Function*
M. CHERNOV, Student
LESTER L. VARGAS, M.D., Director
Cardiovascular Laboratory

3. *Gonioscopy and Tonography in the Diagnosis and Treatment of Glaucoma*
H. FREDERICK STEPHENS, M.D., Surgeon-in-Chief
MILTON G. ROSS, M.D., Assistant Surgeon
Department of Ophthalmology

4. *Middle Ear Prosthesis for Otosclerosis*
WENDELL ROBINSON, M.D., Assistant Surgeon
Department of Otolaryngology

GUIDES FOR DRUG EXPENDITURES FOR WELFARE RECIPIENTS

THE FOLLOWING REPORT, submitted by the Council on Medical Service of the American Medical Association, was adopted by the House of Delegates of that Association at its meeting in Washington, D.C., on November 30, 1960.

Preface

As noted in the Annual Report, the Committee on Indigent Care scheduled its second regional conference in New York City in July with representatives of ten welfare departments and state medical associations. The meeting was well attended and the discussion of this problem, as well as American Medical Association interest in it, was welcomed by those present.

The Committee, through two regional meetings, discussed welfare drug expenditures with medical society and welfare representatives from seventeen states, as well as with guests from several state pharmaceutical associations. The selection of states invited was sufficiently large that, in the Committee's opinion, all proposed methods of reducing drug expenditures for welfare patients were discussed, and all shades of opinion on this problem expressed.

On the completion of the second regional conference, the Committee on Indigent Care and the Subcommittee on Drugs of the American Public Welfare Association met and prepared *Suggested Guides for Drug Expenditures for Welfare Recipients.* This statement has since been approved, with revisions, by the Council on Medical Service of the American Medical Association and the Medical Care Committee of the American Public Welfare Association. The Council on Medical Service *recommends that the House of Delegates approve the following guides* as enunciating the proper areas of responsibility for the welfare agency, the medical profession, and the welfare patient in keeping welfare drug expenditures at the most economical level consistent with good medical care.

Introduction

Increasingly, state and local governmental units are accepting responsibility for direct payment to physicians, hospitals, nursing homes, and pharmacists for services rendered to welfare recipients, instead of expecting the recipient to pay health expenses from his cash grant. The cost and utilization data available from direct payment procedures have revealed that drugs are a factor in the steadily increasing expenditures for medical assistance.

In recent years, therefore, health and welfare agencies administering welfare medical care programs and their medical advisory committees have become increasingly concerned with the expenditures for prescriptions for their clients. The wide variety of new drugs available in recent years, the high price per prescription for some of them, and especially the unpredictability of expenditures have made this a controversial budget item in many areas.

In the fall of 1959, the Subcommittee on Drugs of the American Public Welfare Association's Medical Care Committee and the Committee on Indigent Care of the American Medical Association's Council on Medical Service began a joint study of possible ways of reducing drug expenditures through joint action of health or welfare agencies and the medical profession, so that their mutual responsibility to provide good medical care for the welfare recipient could be fulfilled without unnecessary cost to the taxpayer.

The prescription is an intrinsic part of the physician's treatment. If the patient does not purchase the prescribed drug from his grant, or if the health or welfare agency is unable to meet the cost of purchasing needed drugs, much of the physician's and hospital care provided may be wasted.

The following suggestions for co-operative action do not, in all cases, apply solely to drug expenditures nor do they necessarily include all ways of keeping this expenditure at a reasonable level; administering agencies will do well to work with pharmaceutical organizations on other aspects of this problem. The present statement, however, deals primarily with relationships between the health or welfare agency and the medical profession, and primarily with drug expenditures.

*A. Public Welfare Agency Responsibility**

1. *The agency must be concerned both with the quantity and quality of care for welfare recipients and with the economical use of public funds.*

Acting as the community's agent in financing

*"Public welfare agency," as used in these guides, refers not only to welfare departments but also to any other public agency administering a medical care program for the needy, including health departments and special commissions.

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Aristocort

Triamcinolone has long since proved its unsurpassed efficacy and relative safety in the therapy of *rheumatoid arthritis, inflammatory and allergic dermatoses, bronchial asthma,* and all other conditions in which corticosteroids are indicated. But ARISTOCORT has also opened up new areas of therapy for selected patients who otherwise could not be given corticosteroids. Medicine is now in an era of "special-purpose" steroids.[1]

One outstanding advantage of triamcinolone is that it rarely produces edema and sodium retention.[1,2]

The clinical importance of this property cannot be overemphasized in treating certain types of patients. McGavack and associates[3] have reported the beneficial results with ARISTOCORT in patients with existing or impending cardiac failure, and those with obesity associated with lymphedema. Triamcinolone, in contrast to most other steroids, is not contraindicated in the presence of edema or impending cardiac decompensation.[3]

Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

GUIDES FOR DRUG EXPENDITURES

continued from page 136

the health care of the needy, the agency should not be satisfied with "minimal" care, but should not expend more tax funds than are *essential* to provide good care. The American Public Welfare Association has stated that "Good medical care should meet both quantitative and qualitative standards."[1]

2. *In regard to medicaments, therefore, the agency should encourage efforts to reduce expenditures, but without interfering with the physicians' prescribing drugs necessary to proper medical treatment of the patient.*

   Whatever methods are used to reduce expenditures, leeway must be left for exceptions, when medically justifiable, and for appeal of agency decisions by the attending physician.

3. *Professional direction, supervision, and consultation are essential to the establishment and operation of a program which is both economical and medically adequate.*

   The soundest program is one conceived and administered with the help of a medical director or consultant, and with the aid and support of an advisory committee representing the medical profession. This professional direction and support enables the agency to develop its program on the basis of good practice in the various fields of medicine and, in addition, provides a sound liaison with the local medical profession for interpretation of agency policy and mediation of professional complaints.

   In reference to prescription costs and utilization, the agency should also maintain liaison with the local pharmaceutical association and obtain its assistance in the development and application of policy and in assuring continuity of service. Large agencies may find the employment of staff pharmacists helpful in this regard.

4. *The agency should assume responsibility for training of caseworkers in a basic understanding of illness and in the way a worker can help the physician achieve his treatment objective.*

   The worker may be able, if he has the necessary background of training, to help the recipient understand his responsibility as a patient. He may also help to make sure patients are obtaining and using prescribed drugs in accordance with physicians' instructions. With proper liaison between the welfare agency and the medical profession, specific patient problems may also be solved through agency action or through conferences between individual physicians and caseworkers.

B. Medical Profession Responsibility

1. *The individual physician and the medical profession as a group must also be concerned with maintaining a proper balance between adequate medical care for the welfare recipient and economical use of public funds.*

   It is the official policy of the American Medical Association that "patient care provided in tax-supported health service programs for the needy should meet as high standards of quality and adequacy as can reasonably be made available to others in the community"[2] and that the medical profession should maintain a "continuous and active interest and participation . . . in the whole problem of aid to the needy, including administration, eligibility, financing, and the range and quality of medical services provided."[3]

   Physicians are interested in seeing public funds used effectively to provide adequate care for their welfare patients; as taxpayers, they are also concerned that these funds be used as economically as possible in achieving this goal.

[1] "Tax-supported Medical Care for the Needy," *Public Welfare*, Oct., 1952

[2] "Guides for Medical Societies in Developing Plans for Tax-supported Personal Health Services for the Needy," adopted by A. M. A. House of Delegates, December, 1956

[3] Annual Report of Council on Medical Service to House of Delegates — December, 1959

2. *The individual physician, as the key person in care of the welfare patient, must, therefore, take into consideration not only the medical but the financial aspects of various acceptable modes of treatment.*

   In some cases, the more expensive of two applicable drugs may result in a shorter treatment period, thus effecting economies in other areas. In other cases, less costly drugs may be just as effective.

3. *With particular respect to prescriptions, the individual physician should examine his own prescribing habits to determine whether he can treat welfare patients as effectively at less cost to the welfare agency.*

   Recognizing that the physician's primary obligation is the health needs of his patient, specific suggestions as to ways economies may be accomplished are:

   a. Emphasis on the use of U.S.P., N.F., N.N.D., and A.D.R. counterpart drugs of equal therapeutic effectiveness when available, when the quality of the product is assured, and when a price differential exists.

   b. Limitations on refills: The prescription should be written only for the quantity of the medicament indicated by the patient's current condition, and in such a form as to prevent refills unless specifically authorized by the physician.

   c. Use of standard quantities: Physicians should familiarize themselves with the manufacturers' package sizes of drugs. It may be less expensive to prescribe this quantity, when appropriate to the treatment.

   d. Instruction of patient: Since, due to his situation as a welfare client, the patient may be treated by a number of physicians during a brief period, the physician may have to take extra pains in explaining the proper use of drugs prescribed. The physician will, of course, determine whether the patient is taking any other medication, whether prescribed by another physician or obtained from other sources.

4. *Both the individual physician and medical society should become and remain well-informed concerning the functions and limitations of the welfare medical care program in the community.*

   The medical profession will be better equipped to fulfill the double responsibility of adequate care and economy if it understands the over-all program and problems of the agency. This particularly applies to the agency policies on drugs, since, if the physician prescribes a drug for which the agency will not pay, the patient may not obtain the medication and treatment may be vitiated. Individual physicians may be informed concerning the program through their society's liaison with the agency, through material distributed by the agency, and through individual contact with agency staff.

5. *The medical society, for its part, should maintain an adequate, co-operative and responsible liaison with the welfare agency.*

   Welfare agency attempts to provide proper medical direction and advice for the program should be met by the medical society with a corollary effort to assist in providing adequate, economical care. Society co-operation can be particularly effective in clarifying to physicians the need for prescription limitations and in mediating disagreements between the agency and individual members.

C. Patient Responsibility

1. *The welfare recipient must be educated to realize that he, also, has certain responsibilities to assure that care provided is both effective and economical.*

   Recipients should realize that they should be concerned about unnecessary costs. They should also realize that it is in their own best interests that public funds expended for medical services should be used as efficiently as possible. The welfare department through its casework staff is probably the more appropriate agency to carry on this activity although the physician may also find opportunity to explain the patient's responsibility to him.

2. *The recipient should particularly be informed of the importance of early treatment, continuity of care (where the program allows it), and adherence to the physician's instructions.*

   Patients should realize that prompt, effective care can help them achieve partial or complete self-sufficiency more rapidly.

   Efficacy of care and program costs may both be affected by recipients who avoid treatment until seriously ill, who go to a number of different physicians for treatment, and who do not obtain the medicines prescribed. Proper patient education can also help to eliminate unnecessary prescription refills, excessive amounts in an individual prescription, and unrealistic demands for medication.

* * *

The Committee on Indigent Care and the A.P.W.A. Subcommittee on Drugs are also preparing a *background report*, describing various mechanisms now in use in the states, which will be ready for publication shortly for the information of the state associations and welfare agencies.

CANCER SEMINAR FOR PHYSICIANS

(Sponsored by the Cancer Committee of the Rhode Island Medical Society)

Wednesday from 2:00 P.M. – *5:00* P.M., *April 5, 1961*

Auditorium, George Building, Rhode Island Hospital

Presiding: HENRY C. MCDUFF, JR., M.D., Chairman
Cancer Committee, Rhode Island Medical Society

Greetings: EARL J. MARA, M.D., President
Rhode Island Medical Society

Moderator of Seminar: LOUIS A. LEONE, M.D., Director
Department of Oncology, Rhode Island Hospital

PROGESTATIONAL AGENTS IN THE THERAPY OF CARCINOMA OF THE ENDOMETRIUM

RITA M. KELLEY, M.D., of Boston, Massachusetts

Assistant Resident, Massachusetts General Hospital; Instructor in Medicine, Harvard Medical School; Senior Physician-Internist, Pondville (Massachusetts) Hospital

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THE CONTINUOUS ADMINISTRATION OF CANCER CHEMOTHERAPEUTIC COMPOUNDS BY THE INTRA-ARTERIAL AND INTRAVENOUS ROUTES

ROBERT D. SULLIVAN, M.D., of New York, New York

Chief, Oncology Section, Veterans Administration Hospital, New York, New York

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RADIATION TREATMENT FOR CANCER OF UTERUS AND OVARIES WITH SPECIAL CONSIDERATION OF THE ROLE OF SUPERVOLTAGE THERAPY

RUTH GUTTMANN, M.D., of New York, New York

Associate Professor of Radiology, Columbia University;
Director, Department of Radiotherapy, Francis Delafield Hospital, New York, New York

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SURGICAL MANAGEMENT OF CARCINOMA OF THE UTERUS

MICHAEL J. JORDAN, M.D., of New York, New York

Director, Department of Obstetrics and Gynecology, St. Clare's Hospital, New York, New York;
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GENERAL DISCUSSION — Audience Participation

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EXPERIENCE WITH LIVER NEEDLE BIOPSY IN 700 CASES

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IT IS COMMONPLACE KNOWLEDGE that the late decades have seen great progress in the understanding of the etiology and diagnosis of disease, due to the widespread use, in clinical medicine, of techniques which before that time were not dreamed of for experimental use, even on animals. One of the less spectacular, but not less important of these, has probably been the use of needle biopsies of various organs, especially the liver. Over twenty years after the discovery of this technique, we feel able to assess rather exactly its effective value.

The purpose of this paper is to discuss its general indications and contraindications and to give a report of our experience in this field. The illustrations are given only with the purpose to demonstrate some of the most typical or interesting findings, that we encountered in our work, and do not intend to be a complete survey of the many diagnostic possibilities of needle biopsy.

We usually use the lateral approach in the midaxillary line, in the place where by percussion the upper liver border is to be found. If interposition of the bowel is suspected, it must be ascertained by radiography and if confirmed of course no biopsy should be performed. Only in a minority of the cases, when the liver was frankly enlarged and there was no reasonable danger to penetrate the stomach, the gallbladder or the intestines, an anterior approach has been used. Analgesics were freely given before the performance of the examination and during the following twenty-four hours. That the examination did not provoke much distress is well demonstrated by the fact that the patients were usually willing to allow the repetition of the examination sometime afterwards, if requested. Actually, some of them even requested it, a feature which can be explained by the fact that primitive people believe more in what they think to be a surgical treatment than in conservative treatment.

Most of the biopsies have been performed with the Silverman needle,[1] but the last 150 biopsies have been performed with the Menghini needle,[2,3] an Italian invention. Lately this author introduced a new modification, which makes the performance of the biopsy even easier and the need of co-operation of the patient is practically eliminated. This technique is extremely rapid and the patient's discomfort minimal. It is thoroughly described elsewhere.[4] By this aspiration technique only rarely an insufficient specimen, or no specimen at all, is obtained. In the opinion of many authors with which we agree[5] in such rare instances there is no danger in repeating the procedure immediately. The specimen is successively slowly ejected on a small piece of filter paper and placed in a fixative solution with a minimum of manipulation, in order to avoid undesirable breakage. Formalin may be sufficient, but we prefer the Carnoy solution. After only one hour the fixation is already satisfactory and in twelve hours the specimen is ready for microscopic examination.

In daily clinical practice, a satisfactory diagnosis can usually be reached without need to resort to needle biopsy. Nevertheless, a limited but important group of cases cannot be diagnosed without it. In known disease the indication is only relative, but even then the needle biopsy may give useful information for prognosis and treatment. Actually, some authors feel that it should be performed in every case of liver disease, especially with jaundice, because, in spite of the great advances in the understanding of physiologic and biochemical processes in the liver, precise functional methods for establishing the diagnosis and prognosis of hepatic diseases are not yet available and the morphologic study of hepatic tissue obtained by biopsy techniques is and probably will long remain the best means of determining the nature and significance of pathologic processes occurring in the liver.[6]

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Diffuse disease can be demonstrated with the highest accuracy. One of the most frequent of them, i.e., liver cirrhosis, can, as a matter of fact, be diagnosed in almost 100% of the cases.[7,8] Only rarely will a minimal degree of this condition be overlooked.[9]

Sometimes the differentiation between portal and postnecrotic cirrhosis may be difficult.

In focal lesions, experience has demonstrated positive results in about seventy per cent, more than could theoretically be expected. Zamcheck and Sidman[10] state that in case of a single negative result "the performance of multiple biopsies minimizes its diagnostic error." When we performed them, we could further raise the percentage of positive specimens in a substantial number of cases, but our experience is too limited to allow us to give exact percentages.

We can at least come with safety to the conclusion that a normal result can practically exclude any diffuse pathologic liver condition, while the existence of focal lesions cannot be definitely ruled out by it. According to the literature the needle biopsy can successfully diagnose from 72[11] to 85 per cent[12] of the cases. In our experience, it is somewhat difficult to confirm or deny these figures.

We began to be interested in liver needle biopsy ten years ago, and since then we have performed about 700 biopsies. This rather large number is due to the fact that we realized that this procedure would be of special importance in a country like Israel, where a great many of the people suffered long periods of undernourishment, sometimes lifelong, in the Hitler camps or in primitive Oriental countries, and where the large immigration waves of Jews from the Arab countries brought tens of thousands of cases of parasitic infections of the liver. At the beginning we performed many liver needle biopsies because, as is usual, every time that a physician has at his disposal a new tool or technique, he wishes to be in a position to make a true personal evaluation of its possibilities. Now, today we are performing far less liver biopsies, and these only in the more puzzling cases. Many authors[10,12] stress the necessity of a special training for the pathologist in order to get used to the interpretation of the small specimens. At the beginning, we too had some difficulties in arriving at an exact diagnosis in some cases. In due time the accuracy of our results has improved up to 89 per cent while in 8.5 per cent the findings were noncontributory and in only 2.5 per cent misleading—figures which agree with the percentages quoted in the literature.

If now we look at this procedure from another point of view, we find that the needle biopsy corrected incorrect clinical diagnosis in 17.9 per cent in cirrhosis, in 14.6 per cent in hepatitis, in 9.8 per cent in neoplasms of the liver and in 20.6 per cent in obstructive jaundice.[11] The findings of Cogswell were substantially the same as ours with only minor differences.

Berk and Shay,[13] Mayer and Wurl,[14] Fisher and Faloon[15] found even higher percentages—ranging from 26 to 30 per cent—in which the needle biopsy corrected the clinical diagnosis.

The indications are so manifold that there is no need of repeating the long lists found in the literature. Any disease, parenchymal, infective, obstructive, metabolic, tumoral, granulomatous or circulatory, which can involve the liver, is an indication for needle biopsy, when, of course, as has been stated, all other methods have failed to clarify the diagnosis. By general consensus, every case of fever of doubtful origin and long duration, especially in patients over forty years of age, is by itself an indication for liver needle biopsy, as frequently some of the conditions mentioned can be demonstrated in such cases.

In some cases we were able to cultivate the causative organism, e.g., Brucella melitensis, Salmonella typhosa, from the specimen.

There is general agreement that even during surgery needle biopsy is superior to wedge biopsy, as it makes it possible to obtain a deeper specimen, at greater distance from the sub-capsular changes which are sometimes misleading and it avoids the artifacts due to the manipulation of the liver. It is therefore advisable to perform it at the beginning of the operation.[16,17,18]

Let us now describe some cases from our collection as examples. As stated at the beginning, we do not intend to give a complete survey of the many diagnostic possibilities of liver needle biopsy.

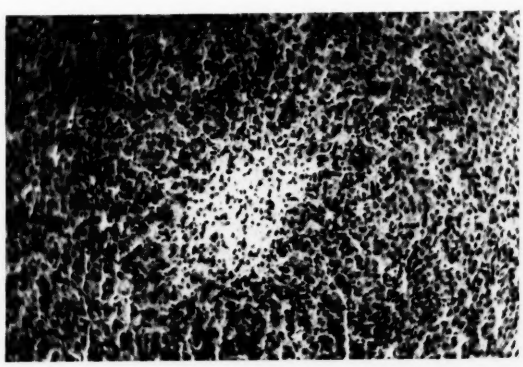

FIGURE 1
Infectious Hepatitis

Case 1

A twenty-three-year-old woman was admitted because of general malaise, weakness and nausea

of one week's duration. She did not notice jaundice, but at physical examination subicterus of the sclerae was found and the liver was somewhat enlarged and tender. The liver function tests were normal with exception of a serum bilirubin of 2 mg. percentage and an alkaline phosphatase of 6.5 Bodansky Units. The erythrocyte sedimentation rate was 22/45. On urinalysis traces of bilirubin were found. The liver needle biopsy showed findings typical of infectious hepatitis.

The rather large extension of the parenchymal damage was unsuspected in this almost anicteric patient.

Case 2

A sixty-five-year-old man suffered from lymphatic leukemia of four years' duration. When he developed serum jaundice, both diseases were easily demonstrated by needle biopsy.

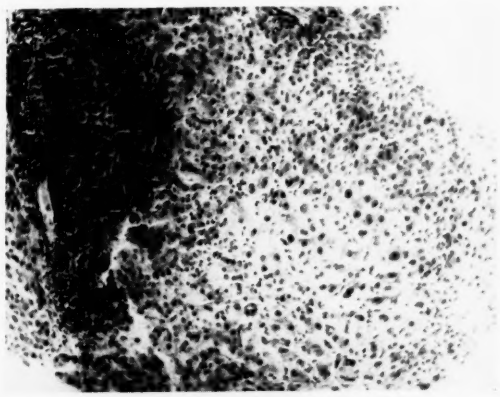

FIGURE 2
Lymphatic Leukemia + Infectious Hepatitis

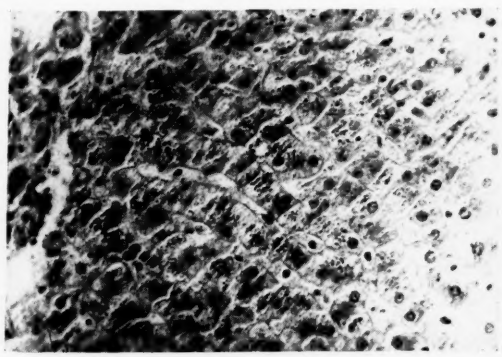

FIGURE 3
Dubin-Johnson's Disease. Central Portion of Lobule; Large Liver Cells with Coarse Granular Crystalline Content (H.E. 450x)

Case 3

A thirty-eight-year-old man, who gave no history of alcoholism, suffered for some weeks before admission with slight unspecific abdominal distress. On physical examination, he was in good condition, the liver was somewhat enlarged and irregular, the spleen was barely palpable. The liver function tests were still normal. The needle biopsy demonstrated a well-advanced liver cirrhosis, with severe distortion of the structure and fibrotic reaction.

Case 4

In a typical case of hemochromatosis with a high serum iron level of 337 micrograms per cent the diagnosis was easily confirmed.

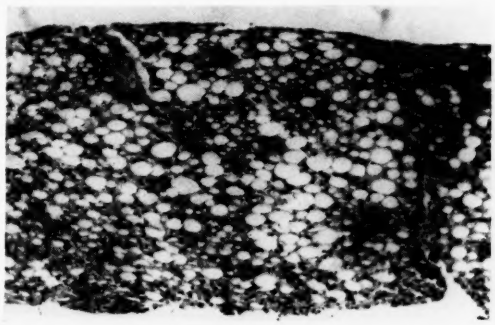

FIGURE 4
Fatty Liver

Case 5

A twenty-two-year-old man suffered from mild jaundice from childhood. On physical exertion or with intercurrent illnesses the jaundice deepened, and then he suffered from severe pain in the right upper quadrant of the abdomen, weakness and lack

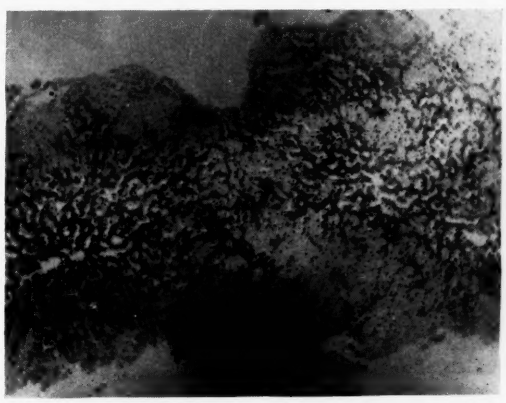

FIGURE 5
Amyloidosis

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of appetite. On physical examination mild jaundice and a slightly tender liver were found and the sedimentation rate and complete blood count were normal. On urinalysis 1 plus bilirubinuria. Serum bilirubin 3.8 mg. per cent, of which 2.9 mg. per cent was direct positive, were noted. The bromsulfaline test showed 19 per cent of the dye retained after forty-five minutes. A cholecystogram showed that the gallbladder was not visualized. Needle biopsy demonstrated "chronic idiopathic jaundice."[19] As this was the second of the twelve cases we collected, we were able to establish the diagnosis of Dubin-Johnson disease on macroscopic examination of the specimen, owing to its pathognomonic black color.

Case 6

A fifty-seven-year-old man, an alcoholic since youth, complained of upper abdominal distress of some years duration, nausea, and sometimes vomiting. He felt weak and anoretic. On physical examination a large liver and a somewhat enlarged spleen were palpated. The liver functions were borderline. Liver cirrhosis was suspected. The liver needle biopsy revealed only a fatty liver. This is a rare case of alcoholism, and he happened to be a new immigrant from Eastern Europe to Israel, where this condition is very rare.

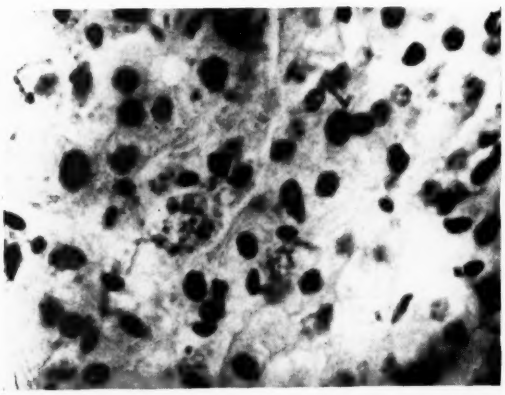

FIGURE 6
Donovan Bodies in Leishmaniasis

Case 7

An old man with long-standing pulmonary tuberculosis, hepatomegaly and albuminuria was considered as a most probable case of secondary amyloidosis. The liver needle biopsy confirmed it.

Case 8

A twenty-year-old Yemenite female was admitted because of huge hepatosplenomegaly. The liver function tests were strongly pathologic, but her general condition was rather good, although there was daily fever up to 102-104 degrees. As

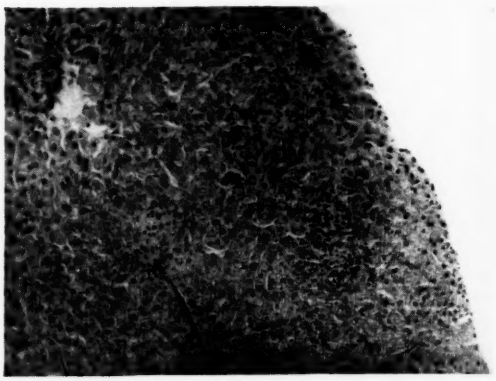

FIGURE 7
Brucellosis

the picture was rather unusual for a simple cirrhosis, a needle biopsy of the liver was performed. The liver structure was normal, but the Kupffer cells were filled with Donovan bodies, the parasites of Kala-Azar. Afterwards we found all the other signs of the disease, including the typical pattern of the fever, with two peaks in twenty-four hours, one during the day and the other during the night, which we had previously missed, the so-called dromedary-type.

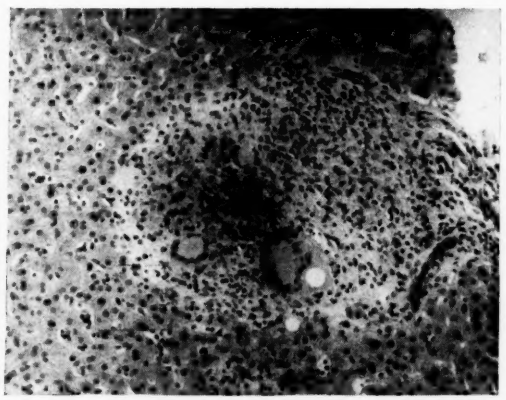

FIGURE 8
Miliary Tuberculosis

Case 9

A fifty-three-year-old woman complained of long-standing fever of three months' duration. She lost twelve pounds weight during this period and felt weak. There were no other complaints. The liver was not enlarged, but somewhat tender. The spleen was palpable. The fever was 102 degrees, the pulse 75. Hb. 10.5 g %. Leukocytes 4:500 with a normal differential picture. Urinalysis was normal. Repeated blood cultures were sterile. An agglutination test for Brucella was 1:100. On liver

needle biopsy a granuloma was found, confirming the diagnosis of Brucellosis.

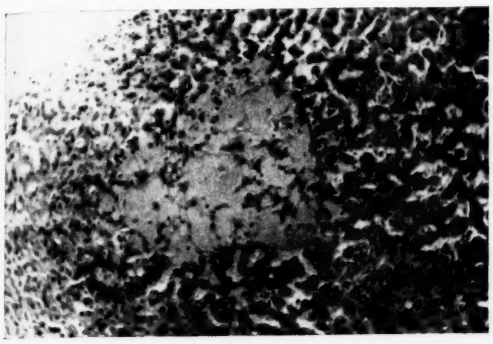

FIGURE 9
Chiari Syndrome

Case 10

A twenty-three-year-old man complained of mild jaundice and general nonspecific symptoms compatible with infective hepatitis, which we suspected clinically. The needle biopsy detected a typical granuloma of miliary tuberculosis.

The radiography of the chest was negative, but it is well known that by this means it is impossible to detect granulomata of less than two millimeters in diameter.

We saw at least four instances of this condition, which healed rapidly after antituberculous therapy. These cases of miliary tuberculosis are often benign and sometimes limited to the liver, most probably of alimentary origin.[20]

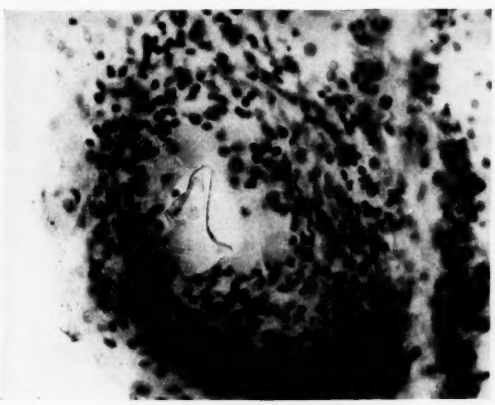

FIGURE 10
Bilharzia

Case 11

A twenty-four-year-old woman complained of sudden attacks of excruciating abdominal pain of four months' duration. Sometime during the attacks some increase in temperature and leukocytosis were observed by the family doctor. On admission the liver was huge and smooth, the spleen was somewhat enlarged and there was no ascites. Sedimentation rate was 54/90, complete blood count, urinalysis and liver function tests were normal. On liver needle biopsy a typical picture of Chiari syndrome (thrombosis of hepatic veins) was found. The large blood pools, due to the extreme liver congestion, were well visible. All over the picture the sinusoids were markedly enlarged.

We were able to collect twelve cases in Israel, and we believe that Lichtman[21] is perfectly right when he asserts that this condition must be much more frequent than generally thought and is frequently overlooked and diagnosed as liver cirrhosis, even at autopsy, if special attention is not paid to the examination of the hepatic veins. The needle biopsy of the liver is of paramount importance in these cases, as it is the easiest and most important means of establishing a diagnosis which clinically can be only suspected.

Tens of thousands of Jews of Yemenite extraction brought with them, from their country of origin, intestinal schistosomiasis. This disease is frequently milder than is usually described in textbooks and many times has been incidentally demonstrated in liver needle biopsy in unsuspected cases.

In addition we feel it necessary to stress the importance of liver needle biopsy as a tool for investigation of the activity of various enzymes,[22] the evolution of hepatic lesions,[23] and the evaluation of both the therapeutic value and the possible hepatotoxic effect of various drugs.[10,24,25,26]

Of course, there are many well-known contraindications, such as hemorrhagic diathesis and marked anemia. We never perform a liver needle biopsy unless the thrombocytes, the bleeding time and coagulation time are normal and the prothrombin activity at least 50 per cent. Prolonged obstructive jaundice is a contraindication too, as penetration of the dilated subcapsular bile ducts can easily provoke bile peritonitis. It is, therefore, general policy and our policy too, to perform a liver needle biopsy during the first three weeks from the onset of jaundice, in every doubtful case in which an obstructive factor is considered possible. Any infection of the pleura, right lower lobe of the lung, and especially within the liver, such as cholangitis, is obviously an absolute contraindication because of the possibility of provocation of generalized peritonitis. A needle biopsy must never be performed unless the liver dullness is definitely demonstrated, or radiography has been performed, in order to ascertain that no bowel interposition has occurred. A hydatid cyst of the liver is another

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contraindication. According to some authors,[15] a tumor can bleed rather easily after punch biopsy, and although we cannot actually consider it as a true contraindication, it is nevertheless a condition which requires special consideration. The only two cases of death that we saw were due to bleeding from liver metastases and from a hepatoma. This is seemingly unusual and most authors consider the biopsy permissible in such cases. In such instances we prefer, if possible, to use an anterior approach, which permits easy surgical intervention, if necessary.

In addition to the two fatal cases that we have mentioned, we saw only two major complications. Once a liver needle biopsy was performed on a patient in whom we did not sufficiently consider the possibility of suppurative cholangitis. A subphrenic abscess developed, which was successfully drained. This was an error of judgment, which belongs to the past: today we would never perform a liver needle biopsy in such a case.

We saw another complication in a patient in which the liver suddenly enlarged, and was tender and painful for some days, after the performance of the biopsy. We suspected a subcapsular hematoma, without proving it, as the patient recovered some days later.

In a certain number of instances, the patients complained of pains in the right shoulder or in the liver region, which we had no difficulty in relieving by free use of analgesics.

As a matter of fact, the contraindications are not frequent in clinical practice, and in most cases the procedure can be performed, but they must be very thoroughly considered and in no way transgressed.

In 1953 a combined group of the Harvard Medical School and the Boston University School of Medicine[10] reviewed over 20,000 liver needle biopsies collected from the literature and five hundred of their own, and came to the conclusion that "the true mortality is less than 1:1000 and judicious use, based on a broad understanding of liver disease, is accompanied by a minimal morbidity and a negligible mortality; less discriminate use by high morbidity and disastrous mortality. It is now apparent that the most conservative application of the method results in a mortality approaching that of other accepted procedures, such as spinal puncture and anesthesia, abdominal and pleural paracentesis, and gastroscopy."

Since then seven years have passed. We think that the additional experience and the development of the Menghini needle have further improved the outlook.

SUMMARY

Needle biopsy of the liver has been described. The literature on this subject has been reviewed. Our experience in this field has been discussed.

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COMPREHENSIVE APPROACH TO THE MANAGEMENT OF DIFFICULT GASTROENTEROLOGICAL PROBLEMS

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PATIENTS WHO COMPLAIN of persistent gastrointestinal distress often are suffering from severe organic or functional disturbances, usually with psychological components. No specific pharmacologic cure is available for such disorders. Treatment must embody a comprehensive program aimed at correction of each individual abnormality of structure or function involved in the symptom complex.

Since, in the pathogenesis of inflammation and ulceration of the gastrointestinal tract, multiple factors are recognized but none is clearly understood, treatment has included various chemical and surgical measures to inhibit gastric secretion and motility, such as antacid and dietary management to neutralize gastric secretions and to protect the damaged mucosa, and hypnotics and ataraxics to influence the central nervous system and psyche. Medical treatment of gastroduodenitis has resembled, in general, the standard regimen for ulcer, but since the pain pattern is different from that of ulcer (pain-food-pain versus pain-food-relief) such management is usually ineffective. Conventional treatment of esophagitis, cardiospasm, and achalasia has been less than satisfactory; the troublesome symptoms of hiatal hernia frequently necessitate operation. Therapy of the exaggerated gastrocolic reflex generally has been discouraging; anticholinergics are not satisfactory in every case.

After diagnosis is established by roentgenography, endoscopy and appropriate laboratory studies, an efficacious and reliable ambulatory treatment is urgently needed. A short initial period in the hospital for diagnosis and initiation of treatment is indispensable in problem cases.

The first consideration is to control pain, and for this purpose a local anesthetic is needed that is powerful enough to check the pain impulses arising in the inflamed gastric mucosa, yet sufficiently nontoxic to permit ingestion in a volume adequate for dispersion over the involved areas. This idea is not new. Cocaine solutions were used empirically by mouth many years ago to relieve the pain of esophageal and gastric distress,[1] but oral administration of a topical anesthetic to act on the gastrointestinal mucosa did not receive organized study until the investigation of Bayer[2] in 1934. For relief of ulcer pain he used doses of 100 cc. of 0.25 per cent solution of an aminobenzoate, administered in the prone or right side position one hour before breakfast. If taken with an antacid there was no anesthetic effect. Procaine was first used orally for peptic ulcer in a similar manner by Hamori[3] in 1943; several later studies of such treatment were reported in the German,[4] Italian,[5] French,[6] and Indian[7] literature between 1943 and 1950. Oral solutions of procaine were also used in an attempt to abolish pyloric spasm;[8] and to relieve cardiospasm,[9] exaggerated gastrocolic reflex, and resultant bowel spasticity.[10]

Pharmacological experiments also demonstrated that various substances possessing local anesthetic properties (antihistamines,[11-13] atropine,[14,15] and procaine[15]) inhibited acid secretion in the stomach.

Certain disadvantages to oral treatment with procaine solutions soon became apparent: 1. *Unreliability of response,* which led to use of excessively large doses (Roka and Lajtha[8] administered up to 1 Gm. in a single dose). 2. *Short duration of effect* (Balfour and Wharton[10] noted relief, after a single dose of 2 oz. 2 per cent solution, for only one or two hours). 3. *Risk of sensitization,* and various other undesirable side effects. 4. *Bitter taste.*

Oxethazaine,[16] a glycine amide belonging to a different chemical series from that of the standard surface anesthetics, is described[17] as more active on the gastric mucosa than other local anesthetics and appears to be of advantage for treatment of gastroduodenitis and other intractable, nonmalignant lesions of the alimentary tract.

Local anesthesia is a function of nerve permeability;[18] loss of pain response occurs through penetration of the cells at nerve endings by an un-ionized anesthetic substance. Dissociation curves were obtained[17] on procaine, lidocaine, and oxethazaine at the pH produced by aluminum hydroxide—3.5. At this level, dissociation for procaine was almost complete; therefore, few molecules of un-ionized base would be available for nerve permeation. (This probably explains the unreliability of oral treat-

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ment with procaine encountered by the earlier workers.) Oxethazaine, however, was significantly less ionized at the gastric pH than either lidocaine or procaine (oxethazaine was 4000 times as potent as procaine by topical application). (Table 1.) Although procaine and lidocaine were effective at the neutral or slightly alkaline pH of the esophagus, in the acid medium of the stomach secretions neither exerted significant anesthetic action.

TABLE 1
Comparison of Duration of Topical Anesthetic Effect[17,19]
% Solution – 20 to 30 minutes' duration

	Topical (rabbit cornea)
Procaine	2 (20 mg./cc.)
Lidocaine	1 (10 mg./cc.)
Oxethazaine	0.0005 (5 microgram/cc.)

Throughout a wide pH range, oxethazaine, 0.0005 per cent, appeared to remain on receptor sites longer than 2 per cent procaine or 1 per cent lidocaine.[17,19] At pH 4.5 both of these rapidly lost potency, but oxethazaine showed little alteration in duration of anesthesia with alteration of the pH of the medium. At 0.0005 per cent concentration and pH 4.5, oxethazaine exerted longer action than did 2 per cent procaine at pH 8.

The oral therapeutic dose of oxethazaine for the human patient—5 cc. of a 0.2 per cent suspension in alumina gel—provides 10 mg. of the topical anesthetic.[16]

Clinical Series

Evaluation of a comprehensive treatment program employing the oxethazaine-antacid combination for ambulatory management of refractory disturbances of the stomach and intestine was conducted, from April, 1959 to August, 1960, in a gastroenterological consultation practice. The total series comprised fifty-six patients, all of whom presented difficult, complicated gastrointestinal problems. Almost all had tried home remedies before seeking medical attention. Most had been referred by their family physicians after considerable trial of conventional treatment, with unsatisfactory results. In this study, therefore, the patients were their own controls; the results of the regimen including oxethazaine were compared with the response to previous treatment as recorded in the clear-cut, usually long established history of each case. Several patients had been hospitalized on one or more occasions and operation had been under consideration for nine. When treatment was begun all were experiencing frequent discomfort and other symptoms that interfered with their daily activities.

Oxethazaine was administered in two types of vehicle. The first thirty-six (group 1) received the standard formula, oxethazaine in alumina gel (Amphojel®);* the second group, comprising twenty patients, received an experimental combination containing oxethazaine in aluminum and magnesium hydroxides.**

Group 1. Of these patients, 61 per cent were females; 39 per cent, males. They ranged in age from 17 to 68, with an average of forty-four years. The occupations represented a typical cross section of the usual practice in internal medicine. In several patients, acute emotional disorders were associated with their gastrointestinal disturbances, for which a variety of ataraxics had been tried without success.

Seventeen reported having had symptoms for "many years," two for eighteen and twenty years, respectively; ten for two to five years, and seven for two to eight months. The diagnostic procedures included complete gastrointestinal studies. Gastroscopy and sigmoidoscopy were done when indicated.

Group 2. Of these patients, 65 per cent were females; 35 per cent, males. Their ages ranged from sixteen to eighty-four years, with an average of forty-six years. The occupations of this group also were diversified.

Seven had been ill for "many years," two for twenty-three and forty years, respectively; three for one to two years, and eight for two to six weeks. Complete gastrointestinal evaluation was carried out in all cases.

The symptoms exhibited by both groups are shown in table 2, and the diagnoses in table 3.

Dosage. Thirty-six of the total series received an initial daily dose of 8 teaspoonfuls of the oxethazaine-antacid mixture—2 teaspoonfuls administered before each meal and at bedtime. This later was reduced to 1 teaspoonful four times daily. For twenty patients the medication was started with a daily dose of 4 teaspoonfuls. Later the medication was administered to many of the patients only as required.

Associated therapy. In addition to the oxethazaine-antacid medication the treatment program included: For twenty-six patients an anticholinergic or parasympathetic inhibitor, with or without sedatives, appropriate diet, and an antacid after each meal. Four received only dietary management in addition to the local anesthetic-antacid. Most received an ataraxic, or, temporarily, a psychic stimulant, in addition to the other medication. One severely depressed patient received electroshock therapy.

The clinical response was evaluated as: (1) *Good* if there was complete relief. (2) *Fair* if there was some improvement but there were still occasional episodes of distress.

*Oxaine® (Oxethazaine in Alumina Gel), available from Wyeth Laboratories.

**Oxaine®—M, available from Wyeth Laboratories.

TABLE 2
Symptoms Presented by 56 Patients

	Group 1 no. patients	Group 2 no. patients
Epigastric, substernal or abdominal pain	28	20
Nausea, vomiting or both	17	7
Epigastric tenderness	13	2
Bleeding	6	1
Burning, bloating, belching	14	11
Regurgitation of food and water	3	2
Dysphagia	1	1
Bizarre gastrointestinal symptoms	1	1
Diarrhea, occasionally alternated with constipation	11	5
Tarry or mucous stools, and rectal discomfort	4	0
Anorexia and weight loss	3	1
Fatigue	7	5
Anxiety	4	6
Depression	2	3

TABLE 3
Diagnoses Established in 56 Patients

	Group 1 no. patients	Group 2 no. patients
Duodenal ulcer, uncomplicated	5	1
Duodenal ulcer, associated with hemorrhage, gastritis, duodenitis, cholecystitis, hepatitis, coronary insufficiency, colon irritability	7	5
Gastric ulcer, associated with duodenal ulcer, antral gastritis, esophagitis and irritable colon	4	2
Gastritis, uncomplicated	6	0
Gastritis, complicated by duodenitis, antral prolapse, cholelithiasis, diabetes, nutritional deficiency anxiety, depression	6	6
Duodenitis, complicated by cholecystitis, nephritis	0	1
Aerophagia, uncomplicated	0	1
Aerophagia, complicated by gastric hyperacidity, anxiety	3	1
Hiatal hernia, uncomplicated	1	1
Hiatal hernia, associated with colon irritability, anxiety	2	0
Esophagospasm, achalasia	1	1
Pyloroduodenal or colon irritability, associated with anxiety	1	1
TOTALS	36	20

Results

Good clinical response was achieved in twenty-three patients of group 1 and thirteen patients of group 2 (64 per cent of the total series). A *fair* result was obtained in ten patients of group 1 (one of whom had the postgastrectomy dumping syndrome) and seven patients of group 2 (31 per cent of the series). *No benefit* occurred in three patients of group 1 (5 per cent). Of the three failures, one patient had a refractory duodenal ulcer and one, a severe gastritis; both had serious emotional problems and had been treated for years with a variety of medications without relief. The third patient, who had a hiatal hernia complicated by anxiety and depression, improved on methaminodiazopoxide alone.

Status of patient at time of this report. Thirteen patients (24 per cent) were discharged after three weeks to ten months of treatment, with an average of four months, because all symptoms had subsided. There has been no relapse in any of these cases. Thirty-six patients (64 per cent) continued on reduced dosage for ten weeks to one year, with an average of six months. Two of these take oxethazaine in the aluminum and magnesium hydroxide vehicle while at home, and during working hours are maintained on an experimental combination of the local anesthetic with aluminum hydroxide and magnesium oxide in tablet form.

For seven patients (12 per cent of the total series) treatment was discontinued in three weeks to four months, in three cases because of treatment failure (5 per cent); in three (5 per cent) because they disliked the flavor; and in one (2 per cent) because of constipation.

Side effects. Constipation. Of the thirty-six

continued on next page

patients in group 1 who received the standard oxethazaine formula, nine (25 per cent of the group) reported constipation. Six patients, who had a good result, were able to continue medication with use of mineral oil. In two, both of whom had a good result, constipation was slight and they were able to complete the treatment course without laxative. One, who exhibited an excellent response in three weeks of medication, discontinued the oxethazaine-antacid mixture because of constipation, and is being satisfactorily maintained on Aludrox® administered after meals.

Taste. Three patients of group 1 (5 per cent of the total series), all suffering from chronic duodenal ulcer complicated by emotional problems, discontinued the medication because they did not care for the flavor.

Discussion

Although oral procaine occasionally had relieved pain for a brief period in some of these patients, distress invariably recurred. In all cases there was no lasting improvement until oxethazaine was added to the regimen. Operation has been indefinitely deferred for all patients for whom surgical measures had been considered. Three patients, one of whom had a duodenal ulcer, and two, who had gastric ulcer complicated by gastroduodenitis, obtained complete relief after three to five weeks of medication, and were led to discontinue oxethazaine. Pain recurred on conventional management alone in eight to ten weeks. On restoration of oxethazaine to the regimen their distress promptly subsided, and there has been no recurrence.

In dealing with difficult, complicated gastroenterological problems, one attempts, after diagnostic evaluation, to relieve the presenting symptoms by (1) appropriate diet, (2) neutralization of excess acidity, (3) control of neurogenic disturbances, and (4) providing emotional relaxation with medication and reassurance. Administration of the oxethazaine-antacid before meals, with suitable supplementary management of diet and reassurance, may be all that is necessary for some of these patients. This local anesthetic-antacid combination usually will stop pain while initial diagnostic studies are being done. The combination is most helpful in antral gastritis with prolapse of the gastric mucosa; and is a useful adjunct to the medical management of peptic ulcer, gastroduodenitis and esophagitis, hiatal hernia, exaggerated gastrocolic reflex, and achalasia. Oxethazaine in alumina gel has been of special value in gastric distress associated with diarrhea.

SUMMARY

Oxethazaine, a glycine amide, shown in laboratory studies to possess more potent local anesthetic properties, regardless of pH, than any surface anesthetic at present available, was administered orally, in two types of antacid vehicle, as part of a comprehensive therapeutic program for fifty-six patients suffering from various chronic, refractory, inflammatory lesions and ulcerations, and functional disturbances of the gastrointestinal tract, in many cases associated with emotional problems. Sixty-four per cent experienced complete remission of symptoms and 31 per cent had some relief. The local anesthetic-antacid regimen is now used almost exclusively for management of such refractory disorders. Laboratory studies that tend to explain the satisfactory clinical response to the compound are reviewed.

Constipation occurred in 25 per cent of the group who received the standard formula containing the local anesthetic in an alumina gel vehicle. In all but one case constipation was easily controlled.

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CHOLEDOCHAL CYSTS

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CONGENITAL CYSTIC DILATATIONS of the common duct, or choledochal cysts, are rarely encountered. An excellent review of all reported cases was published in 1956.[4]

Recently, an infant was admitted to the Rhode Island Hospital with this condition. There had been no previous cases at this institution.

Case Report R.I.H. No. 639551

B. A., a three-month-old white female, was admitted after, on routine examination, a cystic mass had been noted filling the right upper quadrant of the abdomen. There was no clinical jaundice, but there had been some history of pain. Stools had been intermittently green and pale. One episode of diarrhea occurred shortly after birth.

Physical examination: This was a well-developed, but thin, female infant. There was no icterus. Significant findings were limited to the abdomen where a cystic, non-tender, immovable mass about ten centimeters in diameter filled the right upper quadrant.

Laboratory data: Hemoglobin 9.7 grams, WBC 13,000 with normal differential. Urinalysis normal. Intravenous pyelogram normal.

Course: Under general anesthesia, laparotomy was performed through a transverse incision in the right upper quadrant. After mobilizing the hepatic flexure and ascending colon, a cystic mass about 10 centimeters in diameter was visualized. A non-distended gall bladder was attached to this mass by a normal calibre cystic duct. The mass was found to be a cystic dilatation of the entire common bile duct with dilatation to a lesser degree (3 cm.) of the hepatic ducts proximally to a grossly normal liver. No other congenital abnormalities were demonstrated. After 250 cc. of dark green bile had been removed from the cyst, a side-to-side choledochocystoduodenostomy was performed leaving a stoma of approximately one centimeter. A small plastic tube was inserted in the cyst proximal to the anastomosis and brought out through a stab wound as a choledochostomy. Postoperative course was uneventful except for two episodes of fever, probably secondary to regurgitation of food into the biliary system. Cholangiography through the choledochostomy tube revealed only a large cystic mass, but barium swallow revealed the choledochocystoduodenostomy to be patent with some reflux. The patient pulled out the choledochostomy tube on the ninth postoperative day.

The patient was discharged on the sixteenth postoperative day and remained somewhat "fussy" and constipated, with pale stools. About six weeks postoperatively, the stools became green and patient started to eat well and gain weight. Examination seven months postoperatively revealed a normal healthy infant with no abdominal mass palpable.

Discussion

Choledochal cysts result from some congenital deficiency in the wall of the bile ducts. They may involve all or only part of the biliary system. The cysts are not caused by obstruction but, untreated, may themselves result in obstruction with jaundice, cholangitis, and biliary cirrhosis.

The proper treatment is surgical.[2,5] No attempt should be made to remove the cyst because it *is* the patient's bile duct. An anastomosis should be made between the cyst and the small bowel. This can be performed by a simple side-to-side anastomosis with the duodenum or Roux-en-Y type procedure with the jejunum.[3] Apparently, reflux into the biliary system causes little difficulty.

SUMMARY

The case of a patient with a choledochal cyst has been presented. Current views regarding etiology and therapy have been discussed.

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FLEXOR CARPI ULNARIS TENDINITIS WITH CALCIFICATION

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Stanley D. Simon, M.D., Surgeon, Department of Orthopedic Surgery, Miriam Hospital, and Assistant Orthopedic Surgeon, Memorial Hospital, Pawtucket.

CALCIFICATION in or about tendon structures is well known, occurring most often in the supraspinatus tendon of the shoulder. This condition is commonly miscalled "subdeltoid bursitis with calcification," although the authors can certify from personal surgical experience in several hundred cases that the calcific material is imbedded in the supraspinatus tendon substance proper.

A similar clinical entity occurs in the region of the pisiform bone in the wrist, with calcification observed on X-ray studies, accompanied by manifestations of an acute flexor carpi ulnaris tendinitis. Since the acute condition has responded satisfactorily to one of several modes of conservative therapy, scientific verification of the site of the calcific deposit has been lacking except for rare instances. Milch and Green,[1] in 1938, reported one case of surgical exploration carried out by Steindler, in which "definite lime salt incrustation was found within the sheath of the tendon (flexor carpi ulnaris), not in the tendon."

Aitken and Magill[2] reported five acute cases and one chronic case of calcareous tendinitis of the flexor carpi ulnaris. They operated upon the chronic case, finding the large calcific deposit *in* the tendon substance. Other than these two reports, the authors were unable to find any references to surgical exposure of the calcific deposits, but would conclude that the deposits are probably in the flexor carpi ulnaris tendon or peritendinous tissues, drawing on the extensive experience with the allied deposits in the shoulder and the isolated cases cited above. Seidenstein[3] made the interesting observation that in a small series of fifteen cases of flexor carpi ulnaris tendinitis, three developed acute bursitis of the shoulder simultaneously, or shortly afterward.

In our series, one patient developed an acute supraspinatus tendinitis with calcification ("subdeltoid bursitis") two years before treatment for calcified flexor carpi ulnaris tendinitis (Fig. 1c). A second patient developed similar acute shoulder disability with calcification two years following an episode of flexor carpi ulnaris tendinitis with calcification (Fig. 2a, 2b). Certain individuals appear to have a propensity for depositing calcific materials in tendinous tissues.

Etiology

Trauma, infection, and vitamin deficiency have been considered as etiologic factors. No one of these, however, will satisfactorily explain the onset of the disease process. In several cases, we have obtained a history of the performance of some unaccustomed physical act, such as prolonged "push-up" exercises, immediately preceding the onset of acute symptoms. It is evident that in most instances no prior history of trauma is available to explain the presence of calcification which has occurred in or about tendinous tissue.

Clinical Picture

The characteristic onset is a dramatic one, with sudden onset of pain in the volar aspect of the wrist, ulnar side, commonly without any history of antecedent trauma. The pain increases rapidly and may be disabling in a matter of hours. Localized tenderness in the region of the pisiform bone is marked, and this region frequently shows swelling, redness, and increased heat suggestive of infection. It is often misdiagnosed as a cellulitis of the wrist, acute osteomyelitis, or avulsion fracture, and may be treated with antibiotics, without benefit. Even finger motions become painful and limited in the acute phase, and wrist motions are markedly restricted and extremely painful.

X rays show no bony injury or deformity. A longitudinal calcific stippling from 3 mm. to 2 cm. in length is noted in the region of the pisiform bone, varying in density and extent. It is often seen most clearly in the oblique view, and this projection should be included in addition to the anteroposterior and lateral views.

Treatment

Conservative treatment has sufficed to produce a satisfactory result in the authors' experience. Infiltration with procaine and/or hydrocortone has produced satisfactory results in the hands of the authors and other observers.[4,5] Immobilization in a plaster of Paris cast (mid-palm to mid-forearm) for seven to ten days has also been of value in a series of seven cases and has been recommended by Seidenstein.[2] However, in both types of therapy mentioned a period of two to three days of severe pain has been noted in a small number of the injected or cast-immobilized patients. In addition, the transient pain produced by injection of the acutely sensitive pisiform region has been disturbing to some patients. One patient had simultaneous bilateral flexor carpi ulnaris tendinitis, and bilateral forearm casts were impractical.

In one instance in which plaster cast immobilization and codeine sulphate failed to relieve the agonizing pain after twenty-four hours, the cast was removed and X-ray therapy given by the radiologist (H. L.) produced dramatic relief of pain within twelve hours. The authors realized, of course, that this condition is almost always self-limiting and that the abrupt cessation of pain within several hours following X-ray therapy might have been coincidental. Nevertheless, it was considered worthwhile concentrating on X-ray therapy for a short series of cases, and analyzing the results, using no immobilization or other ancillary therapy which might invalidate the results and conclusions.

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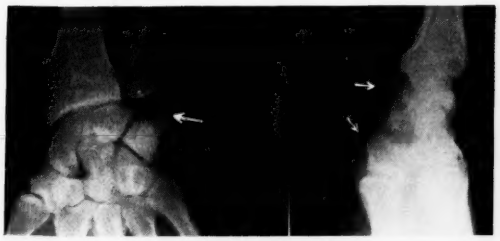

FIGURE 1a

J. G., July, 1959. Note calcifications adjacent to pisiform bone, and along course of flexor carpi ulnaris tendon.

FIGURE 1b

J. G., November, 1960. Sixteen months following therapy. Calcifications have disappeared.

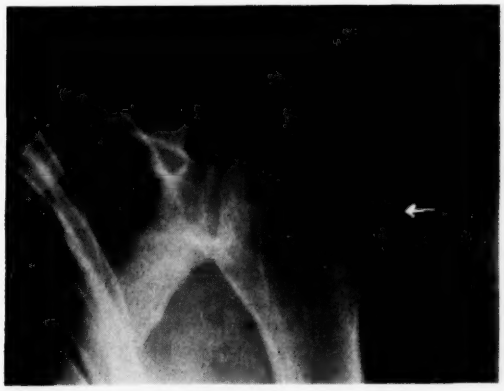

FIGURE 1c

J. G., June, 1957. Large calcification adjacent to humeral head, presumably in supraspinatus tendon, two years prior to wrist disability.

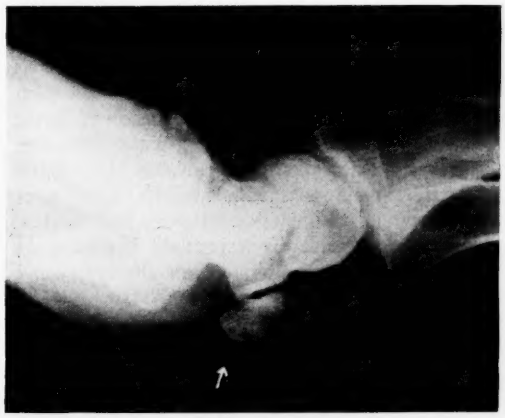

FIGURE 2a

H. L., May 1958. Calcification adjacent to pisiform bone.

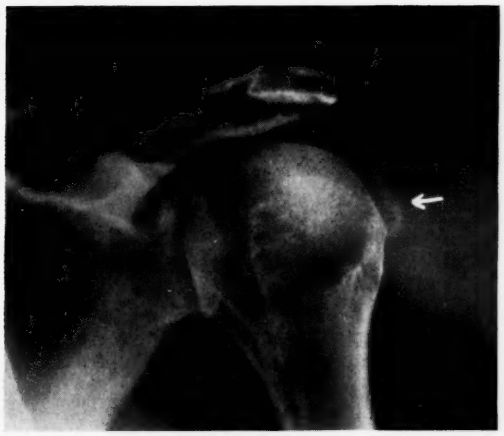

FIGURE 2b

H. L., August, 1960. Calcification near humeral head, with acute symptoms, approximately two years later.

X-ray Therapy

In each instance 200 R in air were administered on three alternate days for a total dose of 600 R. A small portal, measuring 3 x 3 cms., was employed, centering at the site of maximum tenderness, usually slightly proximal to the insertion of the flexor carpi ulnaris tendon. 200 K.V.P., 20 M.A., 50 T.S.D., .5 mm. CU Filter were the factors employed. As occurs occasionally in the treatment of acute tendon calcification elsewhere in the body, on the evening of the first treatment, a mild increase in the local symptoms occurred in several instances. However, by the following morning, in every patient a gratifying improvement in symptoms resulted. From this point on, improvement was so marked that no adjunct to radiotherapy was necessary. In no case was more than 600 R or three treatments given or needed therapeutically. No exacerbation, even with resumed activity, was encountered.

Analysis of Cases

A series of thirteen cases of flexor carpi ulnaris tendinitis with calcification, treated by X-ray therapy alone, is presented. Patients ranged in age from twenty-seven to sixty-three years, with an average age of forty-nine years. One male, age sixty-three, had bilateral acute wrist involvements. There were six males and seven females. Etiology was obscure. In two cases, unusual physical activity involving the wrist appeared to precipitate the acute symptoms.

Two of the patients who were treated with radiation therapy were re-X rayed subsequently to observe any change in the calcium deposits. Both patients were asymptomatic and clinically "cured." In one (J. G.), sixteen months following therapy, no calcifications were present (Figures 1a, 1b). In the other patient (I. P.), nine weeks following radiation therapy, slight residual calcification was noted (Figures 3a, 3b).

CONCLUSION

1. Flexor carpi ulnaris tendinitis with calcification is a painful self-limited clinical entity whose etiology is not well understood. It is frequently confused with inflammatory disease, but may be readily diagnosed by its local symptoms and characteristic X-ray appearance.

2. Many modalities have been successfully employed in treatment of this condition. It is our opinion, as well as that of other writers,[6,7] that X-ray therapy, which is safe and easily administered, provides prompt amelioration of symptoms. Although experience is limited to thirteen cases in this series, radiation therapy is currently employed as the treatment of choice in our hands.

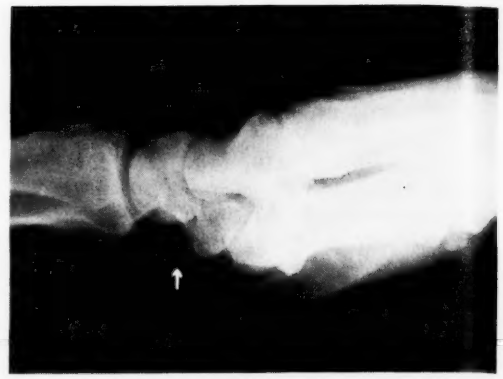

FIGURE 3a

I. P., September, 1960. Stippled calcification adjacent to pisiform; note longitudinal course on lateral view.

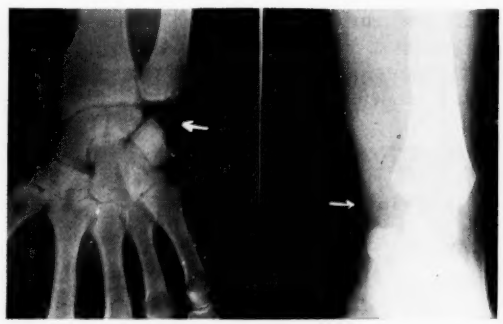

FIGURE 3b

I. P., November, 1960. Slight residual calcification noted, nine weeks following X-ray therapy. Patient asymptomatic.

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Editorials

THE CRYPTO-DIABETIC

THE DETECTION of obscure diabetes mellitus has occupied the attention of the medical profession for many years. There has been a recent intensification of organized effort aimed at case finding, a program which certainly deserves vigorous support. It is our impression, however, that the problem of detection is considerably more difficult and complex than the public relations approach would indicate, and that readily discovered cases of diabetes represent merely the visible portion of the iceberg. Without questioning the desirability of periodic urine examinations, it should be realized that many diabetics remain undetected by this means, and indeed that many remain undetected even in the face of elaborate but uncritical medical studies.

This problem has been on our mind considerably recently because of a rather alarming success over a period of years in uncovering diabetes in patients in whom the disease had apparently been excluded by routine urine and fasting blood sugar studies.

A number of investigators have been similarly concerned. In answer to a recent inquiry in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION on this very question, Doctor Harry Blotner stated: "In general practice, if glycosuria is discovered on routine examination, all too often fasting blood sugar-level and urine sugar-level determinations are ordered. If the results are normal, it is assumed that the patient does not have diabetes. Such a procedure has been the cause of overlooking many mild cases of diabetes." He points out that many thousands of cases of diabetes among selectees would have been missed if this procedure had been followed. Blotner recorded this concept as much as fifteen years ago.

We are primarily concerned in the present remarks with those crypto-diabetics who repeatedly exhibit a sugar-free urine and a normal fasting blood sugar but have disease suggestive of diabetes. In 1952 Stanford Wessler stated: "Since the severity of the diabetic state is not related to the development of gangrene and since in several patients the metabolic defect was recognized only after examination of the blood sugar, diabetes should be suspected in every patient with peripheral arteriosclerosis. It is only in this way that any possible benefits from good management can be realized." Ellenberg more recently has emphasized that the clinician may be confronted with the same dilemma in dealing with neuropathies; he was not always able to find a correlation between neuropathy and the duration or severity of the diabetes. Indeed in a small number of cases neuropathy was the first manifestation of diabetes, unattended by hyperglycemia or glycosuria. In these instances, the diabetes was discovered only upon performance of a glucose tolerance test.

Beaser, as well as Blotner, has affirmed the desirability of adopting a postprandial blood sugar test as the norm, in place of the now traditional fasting blood sugar. Blotner advises, as the routine study, determination of the blood sugar one hour after a heavy carbohydrate meal or 100 grams of glucose, at which time the glucose peak in the blood usually occurs. Yet in some cases, as Beaser has stressed, there is no shortcut for a full glucose tolerance curve. He states, in fact, that if a shortening of the procedure is desirable, the test sample most safely eliminated, is the fasting specimen.

We should like to summarize these thoughts in the following way. Every patient with arteriosclerotic disease not otherwise known to be a diabetic should have, at the very least, a postprandial blood sugar test. If this is not definitive, a glucose tolerance curve should be done. These studies should be routine without exception for every patient manifesting peripheral arterial occlusive disease or unexplained infections. This concept can logically be extended to patients with unexplained neuropathy, suggestive, but unexplained retinopathy, and renal disease.

It is about time that the fasting blood sugar be relegated to the realm of medical history.

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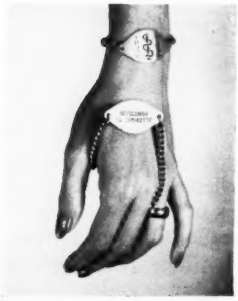
MEDIC-ALERT



Forty-thousand patients across America now wear a medic-alert bracelet or disc engraved on the reverse in telegraphic prose: "allergic to horse-serum," "epilepsy," "diabetes," "hemophilia," or "I am taking anticoagulants." In an emergency or with stranger patients these capsule histories may provide the hard-pressed physician with rapid orientation he will surely welcome. Certainly the plan developed by the Medic-Alert Foundation of Turlock, California, represents a response to a genuine public need attested to by all those who have mailed five dollars for membership and received their emblem.

The Medic-Alert Foundation, started in 1956, now operates as a nonprofit organization and employs seventeen paid workers. The organization maintains a numerical card file containing medical information and identification data on members, available on a twenty-four-hour basis by collect telephone call to Turlock, California, MErcury 4-4917. The emblems, mailed to members, are of either sterling silver or stainless steel and may be had in one of three forms: as a bracelet, a disc on a lady's charm bracelet, or a disc with twenty-four-inch chain for neckwear. A choice of seventeen standard inscriptions is available, but three additional lines may be added at an extra cost of fifty cents the line. This then is the dog-tag which worked so well in the Services, prettied up for the ladies and adapted to civilian use. It is a great improvement over the cards so many diabetics have carried and often lost in the past. The Medic-Alert Foundation, for its manifest public service, merits the support of physicians everywhere.

MAKING MEDICINE MORE ATTRACTIVE

COLLEGE GRADUATES of top-grade academic standing have been a progressively smaller and smaller proportion of those students who choose a medical career as their life work. Studies by the Association of American Medical Colleges bear this out. Furthermore, the number as well as the apparent quality of students who wish to become physicians has been decreasing in recent years.

To explain this situation one can cite on the one hand the increasing cost and long duration of the educational experience that leads to a medical degree and on the other hand the lower cost and earlier achievement of financial independence promised in other fields, particularly in the technical application of various types of engineering.* An attempt to bring undergraduate medical education within the reach of a larger number of the best of the students in our universities is certainly in order. This the American Medical Association is planning. At its recent meeting in Washington "The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals." The following statement by the reference committee was also approved. "This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well-qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility."

In view of the statement that "widespread participation" is suggested, it seems appropriate that the Rhode Island Medical Society and its constituent county organizations should take cognizance of the situation and consider what can be done locally to aid in the implementation of this excellent plan.

*Figures compiled by the Association of American Medical Colleges show that the average cost of four years of Medical School to the students in the 1959 graduating class in the United States was $11,642.

NEEDLE BIOPSY

NEEDLE BIOPSY of tissues and organs has been utilized in various clinics in this country for many years. The development of the Silverman needle appeared to have enhanced greatly the effectiveness of this procedure as compared to the old-fashioned aspiration biopsy. Doctor Chester Jones of Boston demonstrated the value of needle biopsy of the liver in the diagnosis of disease of that organ and advocated its wide adoption. The group at Memorial Hospital in New York have given extensive use to this method for taking biopsies from solid tumors, notably in the breast and neck. Yet the method has never gained widespread acceptance. In most areas of the country the Silverman needle has been used only sporadically. In the case of the liver there has been fear of hemorrhage, and in the case of solid tumors, particularly where operable, there has been concern over the seeding of tumor cells. Casting his shadow over all has been the brooding figure of the pathologist, complaining of the pathetic broken crumbs of tissue, inadequate for decent examination.

The development of a new and ingenious aspiration needle by Menghini in Italy seems to have changed this picture. This new needle has facilitated strikingly the ease, speed, and safety with which needle biopsies may be taken and subjects the patient to a minimum of discomfort. Even more important, pathologists are very favorably impressed with the adequacy of the specimens for diagnostic evaluation.

Published elsewhere in this issue is an excellent report of an extensive experience with this needle, gathered by Doctor Eldad Azkireli of the state of Israel, a recent visitor in this state. Although there had been a small and favorable experience locally with the Menghini needle, the main impetus in this area came from the excellent and impressive presentation of the new diagnostic tool by Doctor Azkireli.

STATE CURATIVE CENTRE BECOMES THE DR. JOHN E. DONLEY REHABILITATION CENTRE

Governor John A. Notte signs legislation renaming the State Curative Centre in honor of Doctor John E. Donley, its medical director for fifteen years, and a former president of the Rhode Island Medical Society, and editor of the RHODE ISLAND MEDICAL JOURNAL.

Watching the Governor sign the legislation are, left to right: J. Austin Carroll, member of the Centre Advisory Board, Jerome McGeharty, member of Centre staff, Dr. Stanley Sprague, member of the Advisory Board, Dominic DiNunzio, member of Centre staff, Clifford J. Cawley, state director of labor, Mrs. John E. Donley, John E. Farrell, executive secretary of the Rhode Island Medical Society, Edward S. Farrell, deputy director of labor, and Anthony DiPinto, executive assistant, State Curative Centre.

REPORT OF THE PRESIDENT

to the Corporation of the Rhode Island Medical Society Physicians Service at Its Twelfth Annual Meeting, at Providence, Rhode Island, January 25, 1960

CHARLES J. ASHWORTH, M.D.

It may seem paradoxical, even contradictory, to state at this twelfth Annual Meeting of the Corporation of Physicians Service that the year 1960 was a success, particularly when the treasurer's report showed a deficit of $109,000.

Despite this dollar-and-cent loss, a brief review of our accomplishments will be convincing proof that the year was, in final analysis, successful, and the financial deficit presents no serious threat to the operational stability of the Plan.

On the plus side, among other things, we look back upon the adoption of revised income limits and becoming an official Blue Shield plan.

Physicians Service led the nation in the percentage of enrollment among federal employees, 86%, as indicated by the latest U.S. Civil Service Commission report. This means that 86% of the federal workers in Rhode Island selected Blue Cross and Physicians Service. Less than 6% chose the plan underwritten by the Aetna Insurance Company, and the remaining 8% was spread among the various other plans available. Including federal workers and dependents, this group represents over 27,000 Rhode Islanders. Nationally, 2,800,000 (54% of the total) selected Blue Cross-Blue Shield.

Another significant result of the enrollment was the selection of higher benefit programs by the federal workers. Offered a choice between a high and low benefit program under most plans, the higher benefit program was chosen by about 80% of the employees. Thus, the largest group in the nation indicated a preference for comprehensive health protection and a willingness to pay the necessary cost for better benefits.

Our total number of subscribers increased by 18,144 during 1960, while the number of firms purchasing Physicians Service for their employees jumped from 1,243 to 1,321, an increase of 78. It is further significant that although a year ago anxiety in certain areas portended a marked reduction in the number of participating physicians, the total at the end of 1960 was 30 more than in 1959, that is, 967 as against 937. These figures certainly reflect confidence, not only on the part of the buying and subscribing public, but on the part of the participating doctors whose professional contributions make this Plan possible.

Surgical-medical benefits provided for subscribers last year totaled $7,958,206, or an increase of almost $1,000,000 ($978,028) over the previous year.

Membership rose to a new high, 577,903, or over 70% of the eligible population in Rhode Island, a record which leads the nation among statewide Blue Shield plans; and again, the lowest administrative expense ratio in the nation among similar plans was recorded, 5.5% or 0.2% lower than 1959. There are now over 134,000 members under Plan B.

A brief résumé of other fields of development shows that inclusion of handicapped children over age 19 under regular family membership, and the introduction of a special contract with reduced rates for college students. This was inaugurated in August, and more than 1,100 were enrolled under the student contract by the end of the year.

The issue of the over-65 element of our population will remain uncertain, pending Congressional action. A study this year by our actuary, Mr. Clapp, showed that 77% of the self-supporting population over age 65 in this state is protected by Physicians Service. This is significant testimony to the community contribution of the Plan.

At the suggestion of the Medical Economics Council, on which Physicians Service has representation, the Rhode Island Medical Society recommended the appointment of utilization committees in the major hospitals in Rhode Island. It is hoped that the combined efforts of Blue Cross-Blue Shield, the Rhode Island Medical Society and the Hospital Association of Rhode Island will be successful in bringing about certain economic improvements in the fields of health and hospital care as has been accomplished by similar groups in other states.

Results of the recent survey of doctors, which will be presented in detail by a later speaker, are not only informative and instructive, but complimentary to the carefully expressed thoughts of all respondents. It reveals the dedication of our doctors to insure the success of this Plan, the majority of whom feel that Physicians Service is achieving its basic objectives with excellence and satisfaction. With the analysis of available figures still incomplete, it is already obvious that this initial "person-

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RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Twelfth Annual Meeting of the Corporation, January 23, 1961

THE TWELFTH ANNUAL MEETING of the Corporation of the Rhode Island Medical Society Physicians Service was held in the Garden Room of the Sheraton-Biltmore Hotel in Providence on January 23, 1961. At the conclusion of dinner, the Corporation was called to order for its business meeting by the president, Doctor Charles J. Ashworth, at 8:25 P.M. The following members of the Corporation were in attendance:

Samuel Adelson, M.D.
Charles J. Ashworth, M.D.
John T. Barrett, M.D.
J. Murray Beardsley, M.D.
Chelcie C. Bosland, Ph.D.
J. Robert Bowen, M.D.
Bertram H. Buxton, Jr., M.D.
Mr. J. Austin Carroll
Mr. George W. Chaplin
Philomen P. Ciarla, M.D.
Harry E. Darrah, M.D.
Michael DiMaio, M.D.
Frank W. Dimmitt, M.D.
Mr. James R. Donnelly
Frederick C. Eckel, M.D.
Peter Erinakes, M.D.
Mr. Emil E. Fachon
Charles L. Farrell, M.D.
Frank D. Fratantuono, M.D.
Henri Gauthier, M.D.
J. Merrill Gibson, M.D.
John F. W. Gilman, M.D.
Seebert J. Goldowsky, M.D.
Stanley Grzebien, M.D.
Edmund T. Hackman, M.D.
Mr. John J. Hall
John C. Ham, M.D.
Arthur E. Hardy, M.D.
Harry Hecker, M.D.
Alexander Jaworski, M.D.
Earl F. Kelly, M.D.
Robert V. Lewis, M.D.
Frank J. Logler, M.D.
Frank MacCardell, M.D.
William MacDonald, M.D.
Earl J. Mara, M.D.
Frank I. Matteo, M.D.
James A. McGrath, M.D.
William S. Nerone, M.D.
Francis W. Nevitt, M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
Ralph Richardson, M.D.
Francis B. Sargent, M.D.
Jack Savran, M.D.
Carl S. Sawyer, M.D.
Stanley D. Simon, M.D.
John Turner, M.D.

Also present were many members of the Claims Committee of Physicians Service and also the following: Mr. Stanley H. Saunders, executive director of Physicians Service, Mr. Edgar H. Clapp, associate executive director, John E. Farrell, SC.D., executive secretary, Mr. William E. McCabe, legal counsel, Mr. Arthur Hanley, assistant executive director of Blue Cross, Mr. J. Lewis Eddy, director of claims, Mr. Frank Addae, director of Public Relations, and Mr. George Peterson, assistant claims manager, and also Mr. Robinson Trowbridge of the advertising agency, Creamer, Trowbridge and Case, Inc.

Annual Report of the Secretary

Doctor Charles L. Farrell, secretary, read his annual report, copy of which was included in the handbook submitted to the members of the Corporation in advance of the meeting and which is made part of the official record of this meeting.

Action: It was moved that the annual report of the secretary be received and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Mr. James R. Donnelly, treasurer, read his annual report, copy of which is made part of the official record of this meeting.

Action: It was moved that the annual report of the treasurer be received and placed on file. The motion was seconded and adopted.

Report of the President

Doctor Charles J. Ashworth, president, read his annual report on the progress of Physicians Service during 1960. (Copy of this report is made part of the official record of this meeting.)

Action: It was moved that the report of the president be received and placed on file. The motion was seconded and adopted.

Citation to the Secretary

Doctor Ashworth noted that Doctor Charles L. Farrell, an incorporator of Physicians Service and a member of its board since 1949, and secretary in 1959-1960, was concluding his service at this meeting. For the Board of Directors he presented to Doctor Farrell an engraved citation citing him for his outstanding service to the Corporation.

Doctor Farrell expressed his appreciation for the honor accorded him, and he commented on the problems that are faced by the Board of Directors, all of whom he praised for their service in the interest of the progress and development of the Voluntary Plan.

Report on Opinion Survey

Mr. Robinson Trowbridge, of the firm Creamer, Trowbridge and Case, Inc., of Providence, reported on a survey of the medical profession of the state relative to its knowledge and criticism of the Physicians Service program. He stated that over 900 questionnaires were distributed, and there has been a usable return of almost 50% of them. He read the results of the survey and distributed to the

continued on next page

members of the Corporation a summary of the answers indicating the significance of the study. Copy of the report on the significance of the survey answers is made part of the record of this meeting.

Federal Employees Health Benefits Program

Doctor Philomen Ciarla made inquiry regarding the provision of X-ray coverage under the Federal Employees Health Benefits Program in Rhode Island.

Mr. Saunders, executive director, explained how X-ray coverage was proposed in the initial contracts submitted by the National Blue Shield Plans which resulted in the development of local literature offering such coverage. However, a fourth and final national contract eliminated X-ray coverage in the doctor's office in order to make the voluntary plans competitive with those of the insurance industry. Since this action came after Physicians Service had made commitments for X-ray coverage to federal employees in Rhode Island, both Blue Cross and Physicians Service, by action of their Board of Directors, had voted to absorb the loss until a new contract can be resolved in October, 1961.

Discussion on the Self-Adjusting Rating Plan

The question was raised regarding the change to a self-adjusting rating plan which would have a serious effect on the premium paid by the person over the age sixty-five.

The executive director reviewed the problem, pointing out the difference between a community rating plan and a self-adjusting rating plan. He indicated that only groups of fifty or more are on the self-adjusting basis, and groups in lower numbers are combined to arrive at an equitable rate for them. He indicated that for the older age person the highest increase in premium was for the 20-dollar plan.

Adjournment

The business of the Corporation completed, the meeting was adjourned at 10:05 P.M.

Respectfully submitted,
CHARLES L. FARRELL, M.D., *Secretary*

Report of the Treasurer
Rhode Island Medical Society — Physicians Service

Condensed Statement of Condition

Rhode Island Medical Society — Physicians Service as of December 31, 1959 — 1960

Assets

	Dec. 31, 1959	*Dec. 31, 1960*
Cash and Due from Banks	$ 161,569.30	$ 88,578.06
Accounts Receivable	670,986.50	752,452.75
U. S. Government Securities	2,747,779.25	2,749,163.80
	$3,580,335.05	$3,590,194.61

Liabilities

Accounts Payable	$ 660,701.78	$ 665,982.54
Accrued for Claims	1,055,581.00	1,245,543.00
Unearned Subscriptions	324,128.15	293,111.55
	$2,040,360.93	$2,204,637.09

Reserves

Reserve for Excess Losses	$ 539,974.12	$ 385,557.52
Statutory Reserve	1,000,000.00	1,000,000.00
TOTAL RESERVES	$1,539,974.12	$1,385,557.52
TOTAL LIABILITIES AND RESERVES	$3,580,335.05	$3,590,194.61

Statement of Earnings

INCOME		
Received from Subscribers	$7,094,142.86	$8,227,272.58
Income from Investments	76,801.99	82,001.98
TOTAL INCOME	$7,170,944.85	$8,309,274.56
EXPENSES		
Claim Payments	$6,980,177.98	$7,958,206.12
Operating Expenses	409,385.10	460,162.04
TOTAL EXPENSES	$7,389,563.08	$8,418,368.16
NET LOSS CHARGED TO RESERVES	$ 218,618.23	$ 109,093.60

A few comparisons with the figures of the previous year are as follows:

We have 577,903 subscribers or 72.2% of the eligible population of the state of Rhode Island. This is the first full year of experience with the "B" plan and 23% of the total subscribers have it.

Gross income of $8,309,274.56 reached an all-time high and represents an increase of $1,138,329.71 or 16% more than last year. This remarkable increase in gross income was due to the upgrading of many "A" contracts to the more expensive "B" contracts and to approximately 18,000 new subscribers.

The increased gross income was offset by claims amounting to $7,958,206.12; an increase of $978,028.14. Claims represent 95.8% of income.

Operating expenses went up $50,776.94 to a total of $460,162.04 or 5.5% of income, considered one of the lowest rates in the country.

Net loss was $109,093.60 as compared with a loss of $218,618.23 for the previous year. This is the second year that we have operated at a loss.

Investment account remains about the same at $2,749,163.80.

Reserves of $1,385,557.52 are $154,416.60 lower and are sufficient to cover 2.8 months of claims. National Blue Shield requirement is three months.

We sustained losses for the first nine months, but some improvement was noted in the remaining three months, when the new system of rates went into effect. The formula under which we now operate appears to be fairly adequate to allow a small margin of profit in the coming year.

Respectfully submitted,
JAMES R. DONNELLY, *Treasurer*

REPORT OF THE PRESIDENT OF PHYSICIANS SERVICE

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to-person" approach will yield invaluable help in further development of the Plan and formulation of policy.

This year, then, complex as it may have been with difficult decisions and the courage to make them, can be best characterized as a striking example of what one year of time is,—a measure of change. One year ago, I reminded you of two problems that would beset us; one, meeting the requirements for eligibility to participate in the coverage of federal employees; and two, completion of plans for extended coverage beyond our basic A and B Plans. The former is in the past; you have met it with decisive vigor, and the wisdom of your choice is reflected in the accomplishments previously mentioned. The latter still awaits us, but its availability and actual operation, I am confident, will be realized this year since, at the moment, no impediment to this end can be foreseen.

Continued emphasis will be placed this year upon informational exchange and interchange between members of the Corporation, members of the entire profession, and the Board. Initiation of efforts along this line will engender a better understanding and lessen, if not eliminate, confusion.

Twenty years ago, the medical profession responded to the challenge of national compulsory health insurance by developing Blue Shield. Today, a similar challenge faces us in the proposal to utilize the Social Security System for the purpose of underwriting medical care for the over-65 members. It is quite possible that this new technique can be met in 1961 as the old one was, by our profession meriting the continued support of subscribers under Physicians Service enrollment, together with 47 million other citizens enrolled in Blue Shield.

Without question some sacrifice will be necessary, but it will be less if it succeeds in keeping not only doctors, but patients from the domination of political control in the field of medical care. We not only have a good Plan, but one of the very best, and I know you share my earnest hope to keep Physicians Service in this category. It continued to lead the nation in percentage of state population enrollment and lowest operating cost.

Again, may I thank the Board of Directors for their efforts and their support throughout the past year. As usual, the executive and administrative staffs, under the able direction of Stanley H. Saunders, has made an outstanding contribution to the progress of this year. Our appreciation extends to all doctors who, in any way, have helped in achieving this success, the Claims Committee and Professional Advisory Committee, and all committees for their help in completing the routine work of the Board which, incidentally, is not lessening.

As an official item in the permanent record of this 12th Annual Report, permit me a word of special thanks to the secretary of the Board, Doctor Charles L. Farrell, who, this evening, terminates a decade of unselfish effort in promoting the aims and ideals of voluntary health insurance in general and our Physicians Service, in particular. His zeal and hard work might well become the pattern for the future in meeting and solving the never-ending problems of a voluntary plan.

It is now my personal privilege, on behalf of the Board and with the Board's authorization, to present this scroll as a memento of the esteem and gratitude in which Doctor Farrell is held.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting, February 1, 1961

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, February 1, 1961. The meeting was called to order by the president, Doctor Earl J. Mara, at 8:07 P.M. The following were in attendance:

Bristol County: Robert W. Drew, M.D. Kent County: Peter C. Erinakes, M.D. Newport County: Philomen Ciarla, M.D.; Charles Dotterer, M.D. Pawtucket District: Alexander Jaworski, M.D.; Earl Kelly, M.D.; Harry Hecker, M.D.; Bencel Schiff, M.D. Washington County: Hartford P. Gongaware, M.D.; Freeman B. Agnelli, M.D. Woonsocket District: Joseph A. Bliss, M.D.; Saul A. Wittes, M.D. State Health Dept. Director: Joseph E. Cannon, M.D.* Officers of the RIMS (other than delegates): Earl J. Mara, M.D.; Frank W. Dimmitt, M.D.; Samuel Adelson, M.D. Immediate Past President of RIMS: Alfred L. Potter, M.D. Providence Medical Association: John T. Barrett, M.D.; J. Robert Bowen, M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Henry B. Fletcher, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; Robert V. Lewis, M.D.; Frank C. MacCardell, M.D.; William J. MacDonald, M.D.; Frank I. Matteo, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; Stanley D. Simon, M.D.; John Turner II, M.D.

Also present were Peter Mathieu, M.D., chairman of the Social Welfare Committeee; John E. Farrell, SC.D., executive secretary; F. B. Sargent, M.D., chairman, Grievance Committee, and Robert W. Riemer, M.D.

MINUTES OF PREVIOUS MEETING

The president noted that the minutes of the September, 1960, meeting of the House of Delegates had been sent to each delegate and had been published in the Medical Journal.

Action: It was moved that the September, 1960, minutes of the House of Delegates be approved and placed on permanent file. The motion was seconded and adopted.

*Without the power of vote.

REPORT OF THE PRESIDENT

Doctor Mara read a communication from Doctor E. Vincent Askey relative to developments concerning medical and health care as viewed from the national level. Doctor Askey is president of the A.M.A.

Doctor Mara reported that the Council had authorized him to appoint a committee on the prevention and treatment of athletic injuries and he is, therefore, naming as the committee the following: A. A. Savastano, M.D., *chairman;* G. Edward Crane, M.D.; William J. Schwab, M.D.; Edwin B. O'Reilly, M.D.; Salvatore J. P. Turco, M.D., and Charles J. Hutchinson, M.D.

Doctor Mara also announced that Doctor Chafee had resigned as general chairman of the Sesquicentennial Committee due to illness and, therefore, he had appointed Doctor Thomas Perry as general chairman of the committee.

REPORT OF THE SECRETARY

In the absence of the secretary, the president noted that his report had been published in the handbook distributed to the delegates.

Action: It was moved that the report of the secretary be received and placed on file. The motion was seconded and adopted.

* * *

Doctor Earl F. Kelly discussed item #1 of the secretary's report and reviewed the proposal from the viewpoint of the Rhode Island Heart Association.

Doctor Mara relinquished the chair to Doctor Dimmitt, the vice president, and then he personally reviewed the hearing on the subject as presented by Doctor Vose to the Council at its meeting in September.

Doctor Kelly presented the following resolution: *RESOLVED,* that the House of Delegates give permission to members of the Society to prescribe penicillin to their patients for prophylactic prevention of rheumatic fever and rheumatic heart disease only, the penicillin to be supplied by the Rhode Island Heart Association at a nominal cost with no profit to any person or individual.

Action: Doctor Dimmitt called for a voice vote on the resolution. The motion for adoption of the resolution was defeated.

REPORT OF THE TREASURER

The president noted that the annual report of the treasurer was included in the handbook of the delegates.

Action: It was moved that the report of the treasurer as submitted be approved and placed on file. The motion was seconded and adopted.

Board of Directors of Physicians Service

The president noted that the House would nominate four members to serve for three-year terms on the Board of Directors of the Rhode Island Medical Society Physicians Service.

The following members of the Society were placed in nomination: Doctors William J. Butler, Wilfred Carney, Frederick Eckel, Thomas Forsythe, Henri Gauthier, K. W. Hennessey, Waldo Hoey, A. Jaworski, F. J. Logler, G. A. Motta, Meyer Saklad, and Stanley D. Simon.

Doctor Mara appointed Doctors Charles Dotterer and Bencel Schiff as tellers for the written ballot.

The four physicians receiving the highest number of votes were the following: Doctors Eckel, Gauthier, Hoey, and Logler.

Action: It was moved that Doctors Eckel, Gauthier, Hoey, and Logler be declared the nominees of the House of Delegates as directors on the Board of Directors of the Rhode Island Medical Society Physicians Service. The motion was seconded and adopted.

Resolution from Kent County

A resolution adopted by the Kent County Medical Society at its December 7, 1960 meeting was included in the handbook to the delegates.

Action: It was moved that the resolution be received and placed on file. The motion was seconded and adopted.

* * *

A motion was made: That the House of Delegates of the Rhode Island Medical Society instruct its delegate and alternate delegate to the American Medical Association to vote in favor of social security coverage for physicians if such a resolution comes before the House of Delegates of the American Medical Association. The motion was seconded and passed.

New England Postgraduate Assembly

A report on the New England Postgraduate Assembly was included in the handbook to the delegates, and it was discussed by Doctor Francis B. Sargent, president of the Council of the New England Medical Societies. At the conclusion of the discussion, it was agreed that the president should appoint a member of the Society to serve on the program committee for the New England Postgraduate Assembly and it was moved:

That the Rhode Island Medical Society agree to be a co-sponsor of the New England Postgraduate Assembly to be held in Boston in November, 1961. The motion was seconded and adopted.

Communications

The executive secretary read a memorandum from the Communications Division of the A.M.A. regarding a Columbia Broadcasting System television program scheduled for the evening of Thursday, February 2, on the subject of *The Business of Health—Medicine, Money and Politics.* The memorandum urged members of the medical profession to view the program and to communicate their opinion of it to CBS.

Recommendation from the Pawtucket Medical Association

The following recommendation adopted at a meeting of the Pawtucket Medical Association held on November 16, 1960, was submitted to the House:

That the Rhode Island Medical Society recommend to the Rhode Island Medical Society Physicians Service in regard to revision of the letter sent to the patient in explanation of service bene-

continued on next page

fits, that the following phrase be added at the end of the second paragraph—

"Or if you receive X-ray, maternity or hospital medical services."

Doctor Alexander Jaworski discussed the resolution.

Action: It was moved that the House of Delegates approve of the recommendation made by the Pawtucket Medical Association. The motion was seconded and passed.

Child-School Health Committee

Doctor John T. Barrett reported for the Child-School Health Committee.

He reviewed a communication from the Rhode Island Tuberculosis and Health Association regarding a tuberculin testing program for schools. After brief discussion it was voted that the matter be referred back to the Committee on Child-School Health for further study.

Report on Mass Immunization Programs

Doctor Barrett reviewed the problem of mass immunization, and he made the following recommendations:

1. In view of the fact that oral polio vaccine apparently will not be generally available in sufficient quantity before next fall for any large scale immunizing program, the House of Delegates of the Rhode Island Medical Society again urges that there be the widest possible utilization of the Salk vaccine in the coming months for the prevention of poliomyelitis.
2. In view of the fact that the Rhode Island State Department of Health has purchased jet-spray equipment for use in mass immunization programs in this state, the House of Delegates recommends that this technique be restricted to use for large groups at clinics for persons unable to pay for the inoculation by their family physician, and that the use at any other clinics be subject to approval by the respective district medical society in the area in which the clinic is to be held.
3. That the Rhode Island Medical Society urge its members, the press, radio and television media, and the public generally, to secure the protective immunization of Salk vaccine before June 1, 1961.

The recommendations were discussed by members of the House.

Action: It was moved that the House approve the report of the chairman of the Mass Immunization Committee and endorse the recommendation submitted. The motion was seconded and passed.

Committee on Medical Economics

Doctor Stanley D. Simon submitted the report of his committee, copy of which was distributed to each member of the House. The report was discussed by members.

Action: It was moved that the House concur with the Committee on Medical Economics that an investment program for physicians be developed on a local rather than a regional basis, and further it voted to authorize the committee to explore such an investment program with major banking companies in Rhode Island, to poll the Society membership to determine its interest in the type of local plan most feasible and that it report its complete findings to the House of Delegates in April. The motion was seconded and adopted.

Medical Defense and Grievance

Doctor Francis B. Sargent gave an oral report on the number and type of cases reviewed by his committee since 1954.

It was moved that the report as submitted by Doctor Sargent for the committee on medical defense and grievance be approved. The motion was seconded and adopted.

Physicians Service

Doctor Mara noted that the House had voted that a report on Physicians Service be given at each of the House meetings. He also noted that the minutes of the meeting of the Board of Directors of Physicians Service had been sent to each member of the House, and he asked if there was need to review or read these minutes.

Action: It was moved that the reports already submitted on Physicians Service should not be read at this meeting. The motion was seconded and passed.

Committee on Social Welfare

Doctor Peter Mathieu discussed the report of the Committee on Social Welfare, copy of which was included in the handbook submitted to the House of Delegates.

Action: It was moved that the report of the Committee on Social Welfare as submitted and the recommendations contained therein be approved. The motion was seconded and adopted.

White House Conference on Aging

Doctor Mara noted that a detailed report on the White House Conference on Aging had been submitted in the handbook to the House of Delegates. He commended the executive secretary for this report, and he urged that all members read it.

Woman's Auxiliary

The president noted that the report submitted by

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the president of the Woman's Auxiliary had been included in the handbook distributed to the House of Delegates.

Action: It was moved that the Woman's Auxiliary report be received and placed on file. The motion was seconded and adopted.

Adjournment

The business of the House completed, the meeting was adjourned at 10:27 P.M.

Respectfully submitted,

JOHN E. FARRELL, SC.D.,
Executive Secretary

REPORT OF THE SECRETARY

The Council has held two meetings since the September session of the House of Delegates. Actions taken at these meetings included the following:

1. A proposal for providing drugs by the Rhode Island Heart Association under a proposed rheumatic fever secondary prophylactic program was not approved.
2. A proposal that free influenza inoculations be given by the Navy to civilian employees was disapproved on the grounds that no emergency existed for such a mass immunization, and civilian employees had ample time to secure inoculations by private physicians prior to the season of year when influenza might be prevalent.
3. An appropriation of $500 was granted the Cancer Committee of the Society for its statewide cancer conference for physicians to be held on Wednesday, April 5, 1961.
4. Committee appointments by the president were approved.
5. Accumulated interest in the Society's savings bank fund for the group Blue Cross-Physicians Service was transferred to the Benevolence Fund of the Society.
6. Approval was given for publishing the special report on medical care of persons over the age 65, as submitted by the Committee on Social Welfare and Aging of the Society to the Governor, in the RHODE ISLAND MEDICAL JOURNAL.
7. The advisability of participation by the Rhode Island Medical Society in a New England Postgraduate Assembly to be held in Boston in November, 1961, under the sponsorship of the Council of the New England State Medical Societies, was referred to the House of Delegates of the Society for its consideration.
8. The president was authorized to appoint a committee from the Council to meet with representatives of the proposed medical assistants group to explore the advisability of a state chapter of such an organization, and to report back to the Council its findings.
9. A favorable opinion was given to the American Medical Association relative to the establishment of a National Medical Political Action Committee.
10. The president was authorized to appoint a committee on the treatment and prevention of athletic injuries, and to request that such committee be urged to consider the feasibility of a sports injury clinic for the athletic staffs of the secondary schools in Rhode Island.
11. Approval was given for the Society to be listed as a co-sponsor for the scientific session on cardiovascular disease to be conducted under the auspices of the Rhode Island Heart Association on March 29, 1961.
12. Support was given the proposal to rename the Rhode Island Curative Center the Doctor John E. Donley Rehabilitation Center.
13. Doctor Earl F. Kelly was named as official delegate of the Society to the Congress on Medical Licensure and Education.
14. The secretary was authorized to send to every member of the Society a copy of the proposed physicians lien law to be introduced in the General Assembly, and to urge membership support of the bill.
15. The annual report of the treasurer for the year 1960 was reviewed and approved.
16. Approval was given that the Society be a co-sponsor with the State Departments of Health and Welfare, and the Chronic Illness Committee of the Rhode Island Council on Community Service a conference on the prevention of disability to be held in April.
17. In Executive Session the Council reviewed a report from the Committee on Medical Defense and Grievance, and voted to suspend a member of the Society for unethical conduct.

Respectfully submitted,

ARTHUR E. HARDY, M.D., *Secretary*

ANNUAL REPORT OF THE TREASURER

A complete financial statement of the Society's general operating account, including the medical journal publication, as well as the investment portfolio established with the Trust Department of the Industrial National Bank in Providence has been reviewed and approved by the Council. All receipts were traced into the bank and canceled checks were examined and checked to disbursement records. Totals of duplicate deposit slips were verified and checked to ledger accounts recording the various classification of receipts. All ledger account additions were verified.

The general fund for operation of the Society's activities amounted to $7,424.23 at the start of 1960. Total receipts from all sources, except the medical journal, amounted to $66,623.84. Expenses, exclusive of those for the medical journal, amounted to $66,501.59. Major building repairs costing over $5,000 reduced the contingency fund, and as a result we ended 1960 with a cash reserve in the general operating fund of $7,546.48, only $122.25 net gain for the year.

The medical journal started the year with a cash balance of $7,927.66. Receipts, including accounts receivable, amounted to $26,258.31. Expenses amounted to $25,299.26 leaving a cash balance, including anticipated receipts from accounts out-

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standing, of $8,886.71. There is indication that our advertising revenue will be reduced in 1961, and therefore this reserve should be held as a cushion against any loss in the coming year in the operation of the publication.

The investment portfolio was increased during the year by the investment of $1,753.38 which represented the dividend accruing to the general operating fund from previous investments. The total dividend return for all the Society's pooled funds amounted to $3,062.03. The market value of the investment portfolio of the Society, plus cash in the Suspense Account for investment, at the end of 1961 was $86,068.

A summary of the Society's 1960 financial condition is as follows:

Cash Balance, Checking Account,	
Industrial Nat'l Bank, Jan. 1, 1960	$ 15,351.89
Receipts, 1960	92,882.15
Total	$108,234.04
Investments, 1960	1,753.38
Balance, General Account	$106,480.66
Expenses, 1960	90,047.47
Cash Balances, Checking Accounts,	
Industrial Nat'l Bank, Jan. 1, 1961	$ 16,433.19
Total Cash and Invested Assets, January 1, 1961:	
Cash Balances, Checking Accounts,	
Industrial Nat'l Bank	$ 16,433.19
Investments, Pooled Fund, Trust Dept.	
Industrial Nat'l Bank, and	
Uninvested Principal Cash	86,068.00
Total	$102,501.19

J. Murray Beardsley, M.D., *Treasurer*

MEDICAL ECONOMICS

The Committee on Medical Economics requests that the House of Delegates instruct it regarding the following matter:

During the past year a committee of the Council of the New England State Medical Societies has studied proposals for an investment program for physicians in the region. In April the Council will propose that a N. E. Physicians Investment Company be incorporated by interested physicians. The Company would start without capital, but it would seek to get enough doctors to purchase stocks in the amount of $100,000 to meet incorporating legal requirements. Standard and Poor would be the investment advisers; the Shawmut National Bank of Boston the depository. No loading charge would prevail, and income of the fund up to $4,000 would be used to pay legal counsel, literature, etc. Standard and Poor would get 2/10% of the first $300,000 invested, and 1/10% when the million-dollar mark is passed.

Subscribers would have to be members of their State Medical Society. Minimum investment would be $25 monthly.

The Committee on Medical Economics has for some time considered the question of an investment program, and it believes that if it is feasible it should be operated at the local level. An interesting plan under which a separate Common Trust Fund could be created locally under which each participating physician could execute a relatively short, to-the-point trust instrument, has been submitted by one Providence bank.

Your Committee, therefore, asks a ruling from the House on the following:

1. Does the House concur with the Committee that if an investment program for physicians is feasible it should be locally operated and administered, rather than on a regional basis?
2. If the House concurs with the Committee on point No. 1, does it authorize the Committee,
   1. to explore the proposal with the major banking companies in Rhode Island,
   2. poll the Society membership to determine its interest in the type of local plan most feasible, and
   3. report its complete findings to the House of Delegates at its meeting in April?

Respectfully submitted,
Stanley D. Simon, M.D., *Chairman*

SOCIAL WELFARE

The Committee on Social Welfare has held several meetings with staff members of the division of public assistance of the state welfare department during recent months, with special consideration being given to the discussion of the cost of drugs for welfare recipients.

In July, 1960, representatives of the Committee and of the state welfare department met with similar representatives from eleven states along the Eastern seaboard for a conference organized by the Committee on Indigent Care of the Council on Medical Service of the American Medical Association. The contributions from Rhode Island are reflected in good measure in the A.M.A. committee report adopted by the House of Delegates of the American Medical Association at its meeting in Washington, D.C. in November.

Recently the Society's committee met jointly with state welfare officials, representatives of the R. I. Pharmaceutical Association and the Apothecary Society of Rhode Island to consider what could be done to encourage, where advisable and feasible, the use of certain expensive drugs by their

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Industrial's *Convertible* living trust

A SPECIAL INVESTMENT SERVICE FOR BUSY MEN

One of the most important benefits of Industrial's *Convertible* Living Trust is its unique flexibility. Thanks to this flexibility, the type of investment service you receive varies in accordance with your requirements.

Under normal circumstances, the *Convertible* Living Trust functions primarily as your investment "bookkeeper," handling the time-consuming chore of detailed record keeping and other paperwork for you. You continue to exercise full control of your own investments.

However, if at any time you become temporarily or permanently unable to actively manage your investments, the automatic "convertibility" of this Trust permits Industrial National's skilled trust officers to assume management of your estate immediately — for as long a period as your circumstances require.

***Convertible* Living Trust advantages:**

- You and your beneficiaries receive financial services conforming to your actual needs and circumstances at any given time
- Helps avert financial losses in any "change-over" period
- Assures maximum protection of your investments if your beneficiaries lack investment knowledge or experience
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Get full information today about our *Convertible* Living Trust. There's no obligation. Write to our Trust Department, Box 1466, Providence, or call JAckson 1-9700, extension 534.

TRUST DEPARTMENT

Industrial
NATIONAL BANK

Member Federal Reserve System
Member Federal Deposit Insurance Corporation

HOUSE OF DELEGATES

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generic name to effect a financial savings to the state.

Your Committee cannot condone any proposal that would in any manner restrict physicians in their treatment of welfare patients, or which would have them provide treatment different than that followed in the care of other private patients.

We have noted the suggestion in the report adopted by the House of Delegates of the American Medical Association at its Clinical meeting in November, 1960, that one way of economy in welfare patients prescriptions might be emphasis on use of "counterpart drugs of equal therapeutic effectiveness when available, when the quality of the product is assured, and when a price differential exists."

However, in our study of the entire problem we find little or no authority at either state or national level to aid the physician in his determination of the reliability of some companies distributing pharmaceuticals at a lesser cost than companies that have earned public and professional confidence by their integrity in the preparation of the medications for which they have expended sizable funds in preliminary research.

We record our concern that the emphasis is being placed too heavily on the physician to prescribe less costly drugs, the therapeutic effectiveness of which he may question, when his professional responsibility demands that he provide the highest standards of care and medication to every patient alike. It appears to your Committee that the basic problem of prescription charges is one that must be resolved first by the pharmacist and the pharmaceutical industry.

As taxpayers, physicians recognize their civic responsibilities to protect and conserve public tax funds. To that end we are of the opinion that every physician should be better informed of the costs of most commonly used drugs, and if a drug is prepared by a reliable pharmacy, and its therapeutic effectiveness, in the opinion of the physician, is satisfactory, and it can be secured at a lesser cost than a similar drug, then every consideration should be given to its use for welfare patients.

Your Committee recommends that the Society conduct, in co-operation with the State Department of Social Welfare, a conference, or a series of conferences if necessary, for these physicians handling over the average public assistance case load for medical care, to inform them of the problem of drug expenditures for welfare patients in Rhode Island, and to seek reasonable ways in which the program may be continued on both a medically and economically adequate basis.

Your Committee appends to this report a copy of the report of the Council on Medical Service of the American Medical Association, adopted by the House of Delegates of that Association in Washington, D.C., in November 1960, relating to *Guides for Drug Expenditures for Welfare Patients.* It recommends that these guides be published in the RHODE ISLAND MEDICAL JOURNAL, and possibly otherwise distributed to the membership of the Society for their information and assistance in the over-all problem.

Respectfully submitted,

COMMITTEE ON SOCIAL WELFARE
Rhode Island Medical Society

ARMY PAPER QUOTES 'EFFICIENCY' HUMOR

Fort Meade, Md. (AP) — "Never makes the same mistake twice, but it seems to me he has made them all once."

It was an officer at Fort Meade describing one of his subordinates in an "efficiency report."

The post newspaper, *Sound Off*, quoted it and other gems recently to show that humor can creep into the most forbidding documents.

"His leadership is outstanding," said another report, "except for his lack of ability to get along with subordinates."

Other officers were rated by their superiors like this:

"A quiet, reticent officer. Industrious, tenacious, careful and neat. I do not wish to have this officer as a member of my command at any time."

"In any change in policy or procedure, he can be relied upon to produce the improbable, hypothetical situation in which the new policy cannot work."

"Needs careful watching since he borders on the brilliant."

"Keenly analytical and his highly developed mentality could best be utilized in the research and development field. He lacks common sense."

"Open to suggestions but never follows same."

...*Reprinted from* THE NEW YORK TIMES, Aug. 28, 1960

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Rhode Island Medical Society, due to an early June start, has completed two important phases of work at the turn of the year. These are in addition to its usual endeavors and customary functions such as regular meetings, membership drive, annual dinner, dance for scholarships, diabetic fair and general co-operation with the Rhode Island Medical Society.

As a result of specific request from the Eastern Regional Traffic Safety Conference held in New York City last year, the representatives from women's and parents' organizations from Rhode Island agreed to co-operate and conduct a similar Traffic Seminar on the state level. At the first organizational meeting on June 2, 1960 our state auxiliary was represented by the state president and her state

safety chairman, Mrs. Alexander Jaworski. Mrs. Jaworski was secretary to this group and attended the three following planning meetings held in conjunction with the State Highway Traffic Division. On September 26, 1960 an all-day Traffic Safety Seminar was held at the Sheraton-Biltmore Hotel in Providence, Rhode Island. Mrs. Joseph Chatigny, Eastern Regional Safety chairman, attended as guest of our state president. The Woman's Auxiliary to the Rhode Island Medical Society is very proud to have had a leading part in organizing and fulfilling the purpose of alerting the public to highway safety problems both nationally and locally.

In November, 1960, the Auxiliary, under the very fine leadership of Mrs. H. Frederick Stephens who with much dedication took time out from her already busy year as Eastern Region Civil Defense chairman, to sponsor a series of television programs. Acting as Publication Relations officer, a combination of Community Service and Publicity, she coordinated this Public Service Feature to answer a peculiar and specific need in this area.

Seven physicians from the State Medical Society went on the air with their corresponding Auxiliary chairmen to:

1. Better acquaint the public of the medical needs in this area.
2. Stimulate interest, and enlist the assistance of volunteers.
3. To make known what actually *is* being done by the Medical Society and Auxiliary for the community.

These six programs which covered the following fields—Community Health, Problems of the Aging, Health Career Scholarships, Mental Health, Safety and Civil Defense—evoked a tremendous response. Pamphlets and information offered to the public were sent for. The Civil Defense show was repeated at a later date, as was the Mental Health program, by popular request. The television channel quoted this an "outstanding program." It is felt a very definite public service was performed and that the Medical Society gained in good public relations as a result of this joint endeavor. Thus the Woman's Auxiliary to the Rhode Island Medical Society has contributed to the National appeal to "preserve and enhance the heritage of American medicine."

Respectfully submitted,
MRS. RICHARD RICE, *President*

WEDNESDAY, APRIL 5, 1961
Cancer Conference
For Rhode Island Physicians Under the Auspices of the Cancer Committee, Rhode Island Medical Society

THROUGH . . .  the Microscope

President Kennedy's Medical History Reviewed

In the February issue of TODAY'S HEALTH magazine, published by the American Medical Association, President John F. Kennedy's medical history is reviewed, and assurance is noted that he currently enters his new work with excellent health and his medical future bright.

Kennedy's medical problems began at an early age. At thirteen he suffered an acute appendicitis attack which "blighted his athletic efforts at Canterbury School in Milford, Connecticut," the magazine said.

A jaundice attack delayed his start at Princeton and a recurrence during the winter compelled him to drop out.

In his sophomore year at Harvard, he suffered a back injury — an apparent ruptured disc in the lower lumbar area — which plagued him for years and nearly cost him his life just six years ago.

His later health difficulties are traced to the agonizing hours and days following the sinking of his PT boat by a Japanese destroyer in the Solomons during the war. The tremendous exertion he expended in swimming long hours to reach help took its toll.

Weakened by exhaustion, Kennedy contracted malaria which lingered for about seven years before he was cured.

The exhaustion plus the malaria (his weight dropped to 127 pounds) may have caused the adrenal insufficiency diagnosed later.

When last tested, it was found that Kennedy's adrenal function was normal. However, he has continued to take corticosteroids by mouth to insure optimum adrenal coverage.

Kennedy also was thrown violently against the deck of the PT boat when it was hit by the destroyer and suffered a severe recurrence of the old football injury to his back.

This time it was associated with sciatica—a usual consequence of a ruptured intervertebral disc when some of the gelatinous nucleus escapes and presses on the nerve roots forming the sciatic nerve to the lower extremity. The pressure throws the muscles into spasm all along the line.

In 1944, he underwent a lumbar disc operation. The pressure on the nerve fibers supplying the muscles was relieved by removing the gelatinous material from the nerve roots where they emerge from the spine.

However, the muscle spasm failed to subside after the operation and it was discovered that the condition was being aggravated because one of Kennedy's legs was a trifle longer than the other. In walking, the inequality in leg length causes an abnormal seesaw movement in the back which puts a continual strain on the spinal muscles.

By the summer of 1954, Kennedy was obliged to use crutches because of the severity of the pain.

Although in a weakened condition, Kennedy decided to gamble on another operation. On October 21, 1954, a lumbar spine fusion was attempted by inserting a small metal plate. The operation didn't take. Then he contracted an infection. Physicians feared death was near and Kennedy was given the last rites of his church.

However, he rallied and attempted to regain his health in Florida. There was little improvement and in February 1955 the metal plate was removed and the infection healed with antibiotics. He continued to suffer pain and use crutches.

Final relief was obtained by novocain injections directly into the cramped muscles. Novocain is used on muscles in spasm to interrupt the vicious cycle of pain-spasm-pain.

Spasm shuts down blood flow to the muscles; ending it restores their circulation. Thus, muscles can recover completely and function normally.

Other corrective measures were taken. To eliminate the seesaw back movement, Kennedy wears a quarter-inch lift in the heel of his left shoe. To support the lower part of his back, he wears a small, corset-type brace.

The medical verdict is that Kennedy's back now is "entirely well."

As evidence of this, the president-elect swims regularly, plays tennis and golf, and bounces his

three-year-old daughter around on his shoulders without any thought about his back.

How Hungry Can You Get?

A December issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION reported the story that a total of 258 objects were recovered from the stomach of a fifty-six-year-old man at the Brooklyn, New York, State Hospital.

The identifiable objects and "an amorphous mass of eroded metal sludge" weighing a total of three pounds, 1¼ ounce were removed by surgery.

Among the 258 items were 26 keys, 3 sets of rosary beads, 16 religious medals, 1 bracelet, 1 necklace, 3 metal chains, 1 beer-can opener, 1 knife blade, 39 nail files, 4 nail clippers, 3 pairs of tweezers, and 88 assorted coins.

Despite the fact that a large amount of iron was oxidizing in his stomach, the patient was suffering a moderate anemia, the article said.

The presence of the objects was discovered during a physical examination of the man, a mental patient at the state hospital since 1936, after his ankles became swollen.

Boston Has Highest Ratio of Physicians to Population

Among the greater metropolitan areas with populations of a million or over, the Boston area has the highest ratio of physicians to population, according to a report issued in December by the Public Health Service.

In the four counties that comprise the Boston-Lowell-Lawrence metropolitan area, where the ratio is highest, there were 207 active non-Federal physicians per 100,000 people in mid-1959. The San Francisco-Oakland area (made up of six counties) ranked second with a physician-population ratio of 199. The consolidated New York-Northeastern New Jersey area (which links eight New York counties with eight counties in New Jersey) was third with 189 physicians for every 100,000 persons.

The physician-population ratios in the remaining seventeen greater metropolitan areas with populations in excess of a million are as follows: Washington, D.C.-Md.-Va. (173); Baltimore, Md. (166); Seattle, Wash. (162); Cleveland, Ohio (161); Philadelphia, Pa.-N.J. (160); Cincinnati, Ohio-Ky. (154); Minneapolis-St. Paul, Minn. (153); Los Angeles-Long Beach, Calif. (151); Chicago, Ill.-N.W. Indiana (143); Buffalo, N.Y. (137); Dallas, Tex. (137); Kansas City, Mo.-Kans. (133); Houston, Tex. (132); St. Louis, Mo.-Ill. (132); Milwaukee, Wis. (128); Pittsburgh, Pa. (117); and Detroit, Mich. (111).

In the 157 standard metropolitan statistical areas with fewer than a million people, the ratio of physicians to population ranged from 459 to 39. Individual areas with high ratios were: Ann Arbor, Mich. (459); Durham, N.C. (392); Galveston, Tex. (284); Madison, Wis. (257); Topeka, Kans. (215); Syracuse, N.Y. (212); and Rochester, N.Y. (200).

Blue Shield Plans Enroll Additional 1,847,000

More than 1,847,000 persons enrolled in the 74 Blue Shield Plans located in North America during the first nine months of 1960, and during the same period the Plans paid out approximately $550,000,000 for care rendered to members, the National Association of Blue Shield Plans announced here today.

"Of special significance is the fact that the $550,000,000 paid to physicians was an all-time high in payments for a nine-month period, and represented approximately 91 per cent of the total income of all Blue Shield Plans," the national association indicated in its report. At the same time, the 74 Blue Shield Plans were reported to have expended less than 10 per cent of total income for administrative expenses.

The national association also said in its report that membership in the 74 Plans reached 46,640,348

continued on next page

DID YOU KNOW?

- **That in 1959, Americans suffered 43 million accidents severe enough to restrict activity or require medical attention.**
- **That nearly 19 million of these accidents occurred at home, more than eight million occurred at work, about four million were motor vehicle mishaps, and various other causes accounted for 12 million accidents.**
- **That accidents hit a peak in the summer months of July, August and September, and reached a low in the cold months of January, February, and March.**
- **That in 1959, for every 1,000 persons in the population, there were 249 accidents severe enough to restrict activity or require medical care.**

as of September 30, 1960—an enrollment of one out of every four Americans. Included in the enrollment figures for the first time are approximately 938,000 Federal workers who selected Blue Shield under the recently enacted Federal Employees Health Benefits Program.

Hearing Problems Reviewed

The belief that loss of hearing is primarily an old folks' complaint may be popular, but it's mistaken according to the December issue of *Patterns of Disease,* a Parke, Davis & Company publication for the medical profession. In fact, the publication points out, almost three out of every five persons with impaired hearing are under sixty-five. And although the incidence of hearing disorders does increase sharply with age, not all elderly persons are hard of hearing.

As many as one third of elderly persons examined in one study had perfectly normal hearing and only a small number—7% showed severe hearing loss. Even when deafness does develop in the elderly person, its causes cannot always be attributed to arteriosclerotic and other degenerative changes of the aging process. One study of older persons cited by *Patterns* showed that in about 50% of the cases over fifty years of age, the causes of hearing loss were similar to those diagnosed in younger persons.

Recent scientific and technological advances may be raising our living standards but they're also inflicting serious damage on our ears.

A report on the effects of noise on hearing is included in the December issue. "Noise-induced hearing loss," the report says, "although not a new problem, is becoming more important because of expansion of industry and development of high-speed machines."

The incidence of hearing loss due to noise depends on such factors as the level of sound, frequency of the noise in cycles per second, the duration of the noise and the susceptibility of the individual. Brief exposure to the noise of a jet engine for instance—a noise level of 130-140 decibels—may have no significant effect. But prolonged exposure to levels of 100 decibels—the equivalent of the noise level of a subway—may cause damage. And if the noise is both prolonged and intense, *Patterns* says it will produce "permanent damage to the inner ear, varying from minor changes in the endings of hair cells to complete destruction of the organ of Corti."

Collegians to Debate Compulsory Health Insurance

The three most often repeated words on college campuses throughout the country this year will be: *Compulsory Health Insurance.*

More than 5,000 college and university students, taking part in the 1960-61 National Intercollegiate Debate program, are currently discussing the proposition: That the United States should adopt a program of compulsory health insurance for all citizens.

The discussion question was chosen through an annual poll of debating coaches throughout the country by the Committee on Intercollegiate Discussion and Debate of the Speech Association of America. Each student engaged in the intercollegiate debate must learn both sides of the question.

Colleges and universities are now holding intra-school elimination contests. From there, invitational debates will be held among schools on a regional basis.

A highlight of the year's debating activity will take place next spring at the United States Military Academy, West Point, New York, at which meeting regional forensic champions from leading universities will compete in the national spotlight.

Because the evolution of health insurance has so important a bearing on the intercollegiate debating topic, the Health Insurance Institute developed an insurance reference kit specifically for this purpose. Nearly 4,000 of these kits were sent to colleges and universities before the opening of the school year for use by debaters, speech departments, and libraries. The Institute has become the central source of insurance information on the debating topic and has made its services available to students for further research.

X-ray Work Covered Out of Hospital

There is a growing trend in the health insurance business toward providing coverage for out-of-hospital diagnostic X ray and laboratory work, the Health Insurance Institute reported recently.

As of the end of 1959, at least 32 million persons were protected by insurance companies against the cost of out-of-hospital diagnostic work as a result of growing public acceptance of policies developed by the insurance industry, said the HII.

Seventy-eight insurance companies in the group field reported at the end of 1959 that they had covered some ten million persons with special riders on hospital policies providing benefits for diagnostic X ray and laboratory work done outside the hospital. The HII said there were more than 400 insurance companies in the group field.

In addition, the twenty-two million persons with major medical expense insurance at the end of 1959 all were covered for out-of-hospital diagnostic work, said the Institute.

There has been a rapid growth in both regular medical and major medical insurance, the HII said. In 1950, insurance companies covered eight million persons with regular medical insurance and about 100,000 with major medical insurance. The insurance company coverage figures today are estimated to be forty million persons with regular medical insurance and twenty-five million persons with major medical insurance.

Food and Drug Issues New Labeling Regulations

The Food and Drug Administration has amended its new regulations requiring changes in labeling used to promote the sale of prescription drugs to physicians. At the same time the Agency extended to February 7, 1961, the effective date of those parts of the regulations previously scheduled to become effective on January 8, 1961. These regulations were published in the Federal Register on December 9, 1960.

Time extensions also have been granted for compliance with certain parts of the regulations scheduled to have become effective on March 9, 1961.

As amended, the regulations will extend the March 9, 1961, date and make these other changes:

1. Permit the use until January 1, 1962, of labels already printed even though they do not contain all the information required in the order published in the Federal Register on December 9, 1960, if the information is elsewhere on the package or in a brochure enclosed in that package.

2. Permit until June 6, 1961, the marketing of drugs already packaged without code or control number on the carton if this number is on the label.

3. Provide for continued use until January 1, 1962, of catalogs and price lists which have some information (but not full disclosure) if sent only to pharmacists and wholesale druggists, and not to medical practitioners.

Where declaration of inactive ingredients is required, flavorings, perfumes and colors may be listed as such, without naming each specifically. Trace amounts of harmless substances used only for individual product identification need no declarations on labels.

In the case of parenterals, water for injection as a vehicle need not be declared under the clarifying regulations. A substance added to make the solution isotonic or to adjust the acidity or alkalinity need only be listed by name and effect, without stating the percentage.

The regulations also were amended to make it clear that no package insert is required solely because the label bears the dosage information called for in another section. Mr. John L. Harvey, deputy commissioner of Food and Drugs, said that the basic question as to required package inserts is being considered in the light of all comments submitted in response to an earlier proposal published in the Federal Register July 22, 1960. Time for submitted comments expired December 22, 1960.

Hospital Use in U.S. Dips to 1940 Level

The annual use of hospital care by the nation's population has declined to the 1940 level of 2.8 days a person, the Health Insurance Institute reported recently.

The average number of days each American spent in general and special hospitals, mental hospitals, and special tuberculosis hospitals was the same in 1959 as in 1940, down after a peak of 3.9 days a person in the wartime year of 1945, and an average of 3.1 days a person in 1951, 1952, and 1953, the Institute stated.

The days in hospital per person for the total population was the same for 1940 and 1959 even though hospital admission rates were 75 per cent higher than 20 years ago, the HII said in its report comparing admission rates, lengths of stay, and population figures.

In 1940 there were 74 admissions to general and special hospitals for each 1,000 persons in the population compared to 130 admissions in 1959, said the Institute.

However, advances in medical science helped reduce the lengths of stay in these hospitals, from an average of 13.7 days in 1940 to 9.6 days in 1959. This decrease was the leading reason why the number of days in all hospitals for each 1,000 persons in the population declined from 2,839 days in 1940 to 2,811 days in 1959.

ON THE MEDICAL LIBRARY BOOKSHELVES

Eleven new titles have been added to the Davenport Collection and are available for circulation:

THE MAN NEXT TO ME. An Adventure in African Medical Practice by Anthony Barker. Harper & Brothers, N.Y., 1959.

A DOCTOR IN MANY LANDS. The Autobiography of Aldo Castellani. Doubleday & Co., Inc., Garden City, 1960.

13 FAMOUS PATIENTS by Noah D. Fabricant. Chilton Company, Book Division, Phil., 1960.

THROUGH STREETS BROAD AND NARROW by Gabriel Fielding. William Morrow & Co., N.Y., 1960.

MASSACHUSETTS. There She Is — Behold Her by Henry F. Howe. Harper & Brothers, N.Y., 1960.

WOMAN DOCTOR OF THE WEST. Bethenia Owens-Adair by Helen Markley Miller. Julian Messner, Inc., N.Y., 1960.

THE TORCH by Wilder Penfield. Little, Brown & Co., Inc., Bost., 1960.

MEDICINE AND SOCIETY IN AMERICA, 1660-1860, by Richard H. Shryock. New York University Press, N.Y., 1960.

MOSTLY MURDER. The Autobiography of Sir Sidney Smith. David McKay Co., Inc., N.Y., 1959.

THE ANTIBIOTIC SAGA by Henry Welch and Felix Marti-Ibanez. Medical Encyclopedia, N.Y., 1960.

DR. IDA. The Story of Dr. Ida Scudder of Vellore by Dorothy C. Wilson. McGraw-Hill Book Co., Inc., N.Y., 1959.

Other purchases were:

CARDIAC SURGERY 1960-1961. Edited by Charles P. Bailey. F. A. Davis Co., Phil., 1960.

THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE. A Text in Applied Physiology by Charles H. Best & Norman B. Taylor. 7th ed. Williams & Wilkins Co., Balt., 1961.

YEAR BOOK OF GENERAL SURGERY (1960-1961 Series). Edited by Michael E. DeBakey. With a Section on Anesthesia edited by Stuart C. Cullen. Year Book Publishers, Inc., Chic., 1960.

THE MEANING OF DEATH. Edited by Herman Feifel. Blakiston Div., McGraw-Hill Book Co., Inc., N.Y., 1959.

INBORN ERRORS OF METABOLISM by David Yi-Yung Hsia. Year Book Publishers, Inc., Chic., 1959.

SO YOU WANT TO BE A DOCTOR by Alan E. Nourse. Harper & Brothers, N.Y., 1957.

MEDICAL PHYSIOLOGY AND BIOPHYSICS. Edited by Theodore C. Ruch & John F. Fulton. 18th ed. W. B. Saunders Co., Phil., 1960.

ON THE INHALATION OF THE VAPOUR OF ETHER IN SURGICAL OPERATIONS: . . . by John Snow, Lond., 1847. Reproduced, Under the Auspices of the Wood Library-Museum of Anesthesiology, New York. Lea & Febiger, Phil., 1959.

PROGRESS IN NEUROLOGY AND PSYCHIATRY. Edited by E. A. Spiegel. Vol. 15. Grune & Stratton, N.Y., 1960.

Review volumes from the Rhode Island Medical Journal were:

SYNOPSIS OF PATHOLOGY by W. A. D. Anderson. 5th ed. C. V. Mosby Co., St. L., 1960.

COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT. Edited by Curtis P. Artz & James D. Hardy. W. B. Saunders Co., Phil., 1960.

CLINICAL MANAGEMENT OF BEHAVIOUR DISORDERS IN CHILDREN by Harry Bakwin & Ruth M. Bakwin. 2nd ed. W. B. Saunders Co., Phil., 1960.

CHILDBEARING BEFORE AND AFTER THIRTY-FIVE. Biologic and Social Implications by Adrien Bleyer, Richard L. Jenkins & Douglas P. Murphy. Vantage Press, N.Y., 1958.

LOVE, SKILL AND MYSTERY. A Handbook to Marriage by Theodor Bovet. Doubleday & Co., Inc., Garden City, 1958.

CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY. v. 13. Human Pituitary Hormones. Editors: G. E. W. Wolstenholme & Cecilia M. O'Connor. Little, Brown & Co., Bost. (1960).

SYNOPSIS OF GYNECOLOGY by Robert J. Crossen, Daniel W. Beacham & Woodard D. Beacham. 5th ed. C. V. Mosby Co., St. L., 1959.

FUNDAMENTALS OF CHEST ROENTGENOLOGY by Benjamin Felson. W. B. Saunders Co., Phil., 1960.

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ON THE MEDICAL LIBRARY BOOKSHELVES

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THE MODERN FAMILY HEALTH GUIDE. Edited by Morris Fishbein. Doubleday & Co., Inc., Garden City, 1959.

MATERNITY. A Guide to Prospective Motherhood by Frederick W. Goodrich, Jr. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959.

MEDICAL AND RENAISSANCE MEDICINE by Benjamin L. Gordon. Philosophical Library, Inc., N.Y., 1959.

WOMEN AND FATIGUE. A Woman Doctor's Answer by Marion Hilliard. Doubleday & Co., Inc., Garden City, 1960.

THE RELUCTANT SURGEON. A Biography of John Hunter by John Kobler. Doubleday & Co., Inc., Garden City, 1960.

CURRENT SURGICAL MANAGEMENT II. A Book of Alternative Viewpoints on Controversial Surgical Problems. Editors: John H. Mulholland, Edwin H. Ellison & Stanley R. Friesen. W. B. Saunders Co., Phil., 1960.

ADVENTURE TO MOTHERHOOD. The Picture-Story of Pregnancy and Childbirth by J. Allan Offen. Audio-Visual Education Co. of America, Inc., Miami. Distributed by Taplinger Publishing Co., N.Y., 1960.

WHAT PRICE MEDICAL CARE? A Preventive Prescription for Private Medicine by Sir Earle Page. J. B. Lippincott Co., Phil., 1960.

DISEASES OF THE NAILS by V. Pardo-Castello & Osvaldo A. Pardo. 3rd ed. Charles C Thomas, Springfield, Ill., 1960.

FROM STERILITY TO FERTILITY. A Guide to the Causes and Cure of Childlessness by Elliot E. Philipp. Philosophical Library, Inc., N.Y., 1957.

PROGRESS IN THE TREATMENT OF FRACTURES AND DISLOCATIONS, 1950-1960, by Thomas B. Quigley & Henry Banks. W. B. Saunders Co., Phil., 1960.

THE POWER OF SEXUAL SURRENDER by Marie N. Robinson. Doubleday & Co., Inc., Garden City, 1959.

HELP-BRINGERS: Versatile Physicians of New Jersey by Fred B. Rogers. Vantage Press, N.Y., 1960.

RESPIRATION. Physiologic Principles and Their Clinical Applications by P. H. Rossier, A. A. Bühlmann & K. Wiesinger. Edited and Translated by Peter C. Luchsinger & Kenneth M. Moser. C. V. Mosby Co., St. L., 1960.

THE PLASMA PROTEINS. Clinical Significance by Paul G. Weil. J. B. Lippincott Co., Phil., 1959., repr. Amer. Pract. & Digest Treat. Sept. 1958.

PATRONIZE JOURNAL ADVERTISERS

For the Medical Profession Only . . .

A Memorandum of the Services Available to Children at

THE MEETING STREET SCHOOL, CHILDREN'S REHABILITATION CENTER

As a Children's Rehabilitation Center we offer:

Comprehensive and integrated out-patient programs of habilitation or rehabilitation, on medical referral only, to infants

pre-school age children
school age up to sixteen

Examples

Neurologic disorders
Cerebral dysfunction
Cerebral palsy
Perceptual-conceptual disorders
Epilepsy
Hyperkinetic behavior
Orthopedic problems
Accident sequelae
  amputations
  burns
Sensory disorders
Metabolic disorders
Spinal cord injuries
Congenital anomalies
Spina bifida
Post-poliomyelitis
Post-encephalitis
Post-meningitis
Arthritis
Muscular dystrophy
Myotonia
Endocrine disorders
Speech problems
Hearing losses, etc., etc.

Meeting Street School, Children's Rehabilitation Center offers to the physician

I. *Diagnostic and evaluation service*
  (a) pediatric-neurological examination
  (b) other medical specialties as required
  (c) physical therapy evaluation
  (d) occupational therapy evaluation
  (e) speech and hearing evaluations
  (f) psychological testing
  (g) medical-social evaluation
  (h) educational evaluation
  (i) staff conference
  (j) complete written report mailed to the referring physician

II. *Treatment:* (Only following the above diagnostic service and only with the approval of the referring physician; treatment is all of the "therapy" type; medication and medical care is the physician's responsibility.)
Parents in all categories have the opportunity for counseling, if they wish. This is a helpful part of treatment.
For infants (up to age 3): Home Development Program:
Parents and baby are given appointments about every three weeks.
Parents are taught by physical, occupational, speech/hearing therapists, exercises, play activities, and sound and language experiences which are to be carried on at home and which will assist in child's development.
For pre-school age (3 to 6 years):
Nursery school, kindergarten and pre-primary groups meet twice a week each, children are seen by the three therapists in a group, again assisting in child's development.
For school age (up to age 16):
Therapy appointments on an individual basis are made after regular school hours.

III. *Referral Procedure*
  (1) *No child is accepted for any service without a written medical referral from a physician or hospital clinic.*
  (2) Mail referral letter or prescription blank to address: Meeting Street School, Children's Rehabilitation Center, 333 Grotto Avenue, Providence 6, R. I.
  (3) Physician and parents will receive notification by mail of the two appointments required for diagnostic sessions. *Physician is urged to attend the staff conference on patient.* The complete "team" which has seen your patient will be present and you can ask them questions.
  (4) While at the Center for final session, parents are told to get in touch with physician in a week. By the time they call you will have received: (a) a letter summarizing medical findings and recommendations,

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and (b) detailed reports of therapists' and psychologist's findings.

(5) You are then responsible for decisions on: (a) carrying out recommendations made, (b) whether treatment at the Center shall be instituted, and (c) whether you wish us to interpret findings further to the parents when treatment at the Center is not recommended.

(6) When we have received your decisions on the above, we contact the parents or you can ask them to call us.

IV. *Referring Physician's Continuing Role*

You are the responsible medical figure with the child and his family.

Annual written summary reports are mailed to you but at any time we will give interim reports either in writing or over the telephone. If your secretary will call us four days before a patient's appointment in your office, or hospital clinic, we will have a report on your desk in time.

V. *Policy of Meeting Street School re fees*

No child is refused service because of inability to pay the clinic fees.

Any request for adjustment, however, must be made by the parents to the social worker.

Diagnostic Service—$25.00 (includes services listed above).

Infant program—3 therapists see the parents and child—$4.00.

Pre-school groups—3 therapists work together with a group—$1.50 each time child attends.

Therapy by appointment—1 therapist $2.00.

Parent counselling is part of the above services. No separate fee charged.

* * *

Meeting Street School, Children's Rehabilitation Center, is an *Easter Seal* service. It is supported by the annual *Easter Seal Campaign*, by gifts and bequests of interested individuals and organizations, by the small fee charged, by research grants.

HOSPITAL USE BY DIAGNOSIS: A STUDY IN CONTRASTS*

Given a variation in the volume of hospital care used in specific social settings under different types of insurance arrangements, are these differences in use concentrated in one or a few medical diagnoses, or are they spread over the entire spectrum of diagnoses? . . . The preliminary results of a study by Health Information Foundation in which hospital use by diagnosis under Blue Cross in Indiana in 1956 was compared with the much higher rates of use under the Saskatchewan Hospital Services Plan in Canada during 1957.

Briefly, hospital use was higher in Saskatchewan than in Indiana for admissions, length of stay, and annual patient-days. Part of this higher use in Saskatchewan was due to the less "favorable" age-and-sex composition of its population; but, even with the adjustment for this factor, hospital use there was much higher than under Blue Cross in Indiana. This higher use in Saskatchewan was substantial in each age-and-sex group of the population. By diagnosis, a considerable proportion of the difference between the two experiences was accounted for by diseases of the respiratory system and by obstetrical care. But in addition to these diagnoses, the substantially higher hospital use in Saskatchewan was spread throughout almost the entire range of medical diagnoses.

The relatively high volume of hospital use in Saskatchewan has attracted attention for some years now. It is generally thought to be associated with a number of "social," i.e., nonmedical, factors. For one thing, Saskatchewan provides hospital care under a government insurance plan, financed through various forms of taxation, so that the total cost of hospital care is spread over the entire population, and direct cost barriers to use for any individual are removed. Also, Saskatchewan is primarily rural, and hospital use in rural areas among insured populations has been noted elsewhere to be higher than among insured populations in urban settings. Still another factor: Utilization in Saskatchewan has risen, since the inception of the Plan, along with an increase in hospital beds and facilities.

Each of these factors, and others as well, is in some way relevant to the comparison between Saskatchewan and Indiana. However, the purpose of this study was not to dwell on these social factors but rather, taking them as given, to explore in detail the medical causes, or diagnoses, accounting for the higher hospital use in Saskatchewan than in Indiana. . . .

Data for admission rates by sex were available from Indiana only for admissions of persons aged 20 and over. In both experiences admission rates for females at ages 20-34 and 35-49 exceeded those for males by a wide margin, and this held true even with obstetrical care excluded. At ages 50-64 and 65 and over, again in both experiences, admission rates for females continued to exceed those for males, but the margin of excess was much smaller.

In summary, part of the higher hospital use in Saskatchewan was due to differences in the age-and-sex compositions of the two populations, and also to proportionately greater use of hospitals in Saskatchewan for obstetrical care and respiratory diseases. In addition, however, hospital use in Saskatchewan was higher for nearly all major diagnostic categories and for each age-and-sex group.

**Reprinted from* PROGRESS IN HEALTH SERVICES, published by the Health Information Foundation, Vol. X, No. 1, January, 1961.

LEST WE FORGET

Extension of Remarks of HON. BEN F. JENSEN, *of Iowa* in the House of Representatives

Monday, January 30, 1961

MR. JENSEN. Mr. Speaker, under leave to extend my own remarks in the RECORD, I include therein the short story of freemen on the sure road to slavery.

Now, altogether, Americans, let us put our feet heavy on the proper brakes, before we suffer the same fate as has every nation on earth that followed too long the call of the Federal regimentors and reckless spenders of the people's tax dollars.

The Story of 10 Little Free Workers

(These are the workers: railroader, doctor, lineman, miner, steelworker, farmer, lawyer, grocer, salesclerk, reporter)

Ten little free workers in this country fine and fair.
But if you cherish your freedom—worker have a care.
Ten little free workers—railroader was doing fine
Until the Socialists got him—then there were nine.
Nine little free workers laughed at railroader's fate
Along came Federal medicine—then there were eight.
Eight little free workers thought this country heaven
But the Government took over utilities, then there were seven.
Seven little free workers—till the miners got in a fix.
Uncle said coal's essential and took over leaving six.
Six little free workers till the day did arrive
The steel mills, too, were federalized—then there were five.
Five little free workers—but the farmers are free no more,
The farms have been collectivized—that leaves only four.
Four little free workers till the Government did decree
All must have free legal advice—then there were three.
Three little free workers—the number is getting few,
But with Government groceries selling food—then there were two.
Two little free workers—our story's almost done,
With clerks at work in Federal stores—that leaves only one.
One little free worker—the reporter son-of-a-gun
Mustn't criticize Government—so now there are none.
Ten little workers—but they are no longer free
They work when and where ordered, and at a fixed rate you see,
And it all could have been prevented if they'd only seen fit to agree
And work together instead of saying, "It never can happen to me."

... *Reprinted from the* CONGRESSIONAL RECORD, January 30, 1961.

MANAGEMENT OF DIFFICULT GASTROENTEROLOGICAL PROBLEMS

concluded from page 154

[18]Krahl, M. E.; Keltch, A. K., and Clowes, G. H. A.: The Role of Changes in Extracellular and Intracellular Hydrogen Ion Concentration in the Action of Local Anesthetic Bases, J. Pharmacol. & Exper. Therap. 68:330-50, 1940

[19]Glassman, J. M.; Hudyma, G. M., and Seifter, J.: Comparative Potencies of a New Series of Local Anesthetics, J. Pharmacol. & Exper. Therap. 119:150, 1957

DID YOU KNOW?

- That the birth rate hits a peak in the summer months of July, August and September and in the winter month of December.
- That the December birth rate jump is highest among middle income families, lower among high income families and lowest among low income families.
- That about 65 per cent of the babies born in the U.S. each year have part of their initial medical expenses paid by health insurance.

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